TRANSCRIPT OF PROCEEDINGS

THE HON RONALD SACKVILLE AO QC, Chair
THE HON ROSLYN ATKINSON AO, Commissioner
MS BARBARA BENNETT PSM, Commissioner
DR RHONDA GALBALLY AC, Commissioner

THE ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

9.30 AM, TUESDAY, 2 MARCH 2021

DAY 3

Kate Eastman SC, Senior Counsel Assisting
Georgina Wright, Counsel Assisting

CHAIR: Good morning, everybody. I welcome everyone who is following this, the third day of Public Hearing 10. The subject matter of this hearing is the education and training of health professionals for the care and treatment of people with disability. We begin, as we do with all our hearings, with an acknowledgment of country.

I wish to acknowledge the Gadigal people of the Eora Nation, the traditional custodians of this land, and pay my respects to their Elders past, present and emerging. I also acknowledge the Wurundjeri people of the Kulin Nation upon whose lands Commissioner Galbally is sitting. I pay our respects to their Elders, past, present and emerging. I also pay our respects to all First Nations people viewing this hearing on the livestream.

The first two days of this hearing were held on 15 and 16 December 2020. Anyone interested in the subject matter of the hearing can bring themselves up to date, if they wish, by reading the transcript of the hearing of those days which is available on the Royal Commission's website.

Today's hearing is being conducted from the Sydney hearing room of the Royal Commission. I am joined in the Sydney hearing room by Commissioner Roslyn Atkinson AO and Commissioner Barbara Bennett PSM. Commissioner Rhonda Galbally AC is participating in the hearing from Melbourne.

Counsel Assisting the Royal Commission at this hearing is Ms Kate Eastman SC who appears with Ms Georgina Wright of counsel.

As Ms Eastman explained on the first day of this public hearing, the format is rather different from that of other public hearings held by the Royal Commission. As I have noted, we are investigating the education and training of health professionals. For obvious reasons, most witnesses today are representatives of educational institutions, professional associations, all bodies responsible for the accreditation of health professionals.

The witnesses today will be giving evidence either remotely or by video. Each of the witnesses will have been sworn or affirmed, as the case may be, prior to their giving evidence. Yes, Ms Eastman.

MS EASTMAN: Good morning, Commissioners. We also acknowledge and pay our respects to the traditional custodians on the lands we are meeting today. We pay our respects to First Nations elders past, present and emerging as well as to all First Nations people following this public hearing.

As the Chair has mentioned, this is the third and final day of Public Hearing 10. In December, Commissioners, you heard from 27 witnesses about the education and training of health professionals in Australia with respect to people with cognitive disability and our focus then was on medicine and nursing.

Today, we convene four panels and you will hear from health professionals and allied health professionals in the areas of speech pathology, pharmacy, psychology, and dentistry. Again, our focus is deliberately on the people and institutions with responsibility for education, training of health professionals and those people who have the capacity to effect change. We will adopt the same format as the December hearing. So before some of the panels, we will revisit evidence from previous hearings and hear again from people with lived experience about their interactions with the health profession. We will then turn to the members of each panel and ask them to address the propositions developed by Counsel Assisting. A copy of those propositions is available on the Royal Commission's website. It's not altered from the hearing in December.

Commissioners, you will recall that the propositions for change are grouped into three main categories. First, framework. That proposes the development of a standardised competency framework to guide the development of all reforms to education and training.

Secondly, the fundamentals, which proposes key content and procedural elements that should guide and inform all training and education. And, thirdly, the training phases, and those are the propositions that set out specific stages to education and training.

This afternoon, we will conclude the hearing with Mr Simon Cotterell, the First Assistant Secretary, Primary Health Care, Department of Health. Mr Cotterell has given evidence at the Royal Commission at Public Hearing 4, and more recently at Public Hearing 5 concerning the impact of COVID-19 on people with disability.

Commissioners, you will recall that in August 2019 the Commonwealth Department of Health convened a roundtable with a focus on people with intellectual disability and their families, together with academics, experts and healthcare providers across a range of disciplines to discuss the challenges facing people with intellectual disability in accessing appropriate healthcare and the opportunities to improve the system.

The Commonwealth Department of Health says this: the National Roadmap will increase recognition that people living with intellectual disability have the right to the same quality and access to health services as every other Australian.

You will hear this afternoon from Mr Cotterell about the progress over the past 12 months, including recent meetings to address education and training of health professionals. We will ask Mr Cotterell about the Commonwealth Department of Health's next steps and the implementation strategies for the various initiatives in the National Roadmap.

Before we commence, can I again remind those following the proceedings that there are protections for witnesses. The *Royal Commissions Act* has a clear objective of protecting witnesses who give evidence before the Royal Commission, and in

particular, again, I want to draw attention to section 6M of that Act that provides that any person who uses, causes or inflicts any violence, punishment, damage, loss or disadvantage to any person on account of the person having appeared as a witness, or given evidence before, or producing documents to the Royal Commission, commits an indictable offence. The maximum penalty for committing such an offence is imprisonment.

Commissioners, there is an additional tender bundle which we have described as Tender Bundle C that contains the evidence relevant to today's proceedings. Commissioners, you will recall that on the first day of the hearing you received into evidence a number of documents that you marked as volumes Tender Bundle A and Tender Bundle B. The exhibits are set out in those two bundles. If it is convenient, may I now tender the further volume of material which is set out in Tender Bundle C, that comprises the statements and documents relevant to today's proceedings and some additional documents arising from the last occasion.

With respect to the documents in Tender Bundle C, could I ask that you receive them and mark them as Exhibits 10-88 through to 10-107, and we'll circulate an updated exhibits list shortly.

CHAIR: Yes, that can be done. Thank you.

EXHIBITS #10-88 TO #10-107 - DOCUMENTS IN TENDER BUNDLE C

MS EASTMAN: Commissioners, I think that there are a number of parties who have been granted leave to appear who may wish to make their appearances.

CHAIR: Yes, thank you. Could I invite any party granted leave to appear who is appearing today to announce their appearances.

MR COSTELLO: May it please the Commission, my name is Costello and I appear on behalf of the Commonwealth.

CHAIR: Yes, thank you, Mr Costello.

MS FURNESS: My name is Gail Furness and I appear on behalf of the State of New South Wales.

CHAIR: Thank you, Ms Furness.

MS McMILLAN: Good morning, My name is McMillan, initials KA, Senior Counsel, and I appear with Ms Clohessy, instructed by Crown Law for Queensland.

CHAIR: Thank you, Ms McMillan. Are there any other appearances to announce? Thank you.

Yes.

MS WRIGHT: Commissioners, the first witness is Claire Hewat of the Allied Health Professions Australia, and so I call her now.

CHAIR: Thank you, Ms Wright. We'll just wait for Ms Hewat to appear on the screen.

Good morning, Ms Hewat, we can see you on the screen now. I hope you can see us.

MS HEWAT: Yes, thank you, good morning.

CHAIR: Good morning. Before I get Ms Wright to ask you some questions, just to ensure you know where we all are, there are three Commissioners in our Sydney hearing room, namely Commissioner Atkinson, Commissioner Bennett and myself, and Commissioner Galbally is joining the proceedings from Melbourne.

I will now ask Ms Wright, who is in the Sydney hearing room, to ask you some questions. Thank you.

MS ELIZABETH CLAIRE HEWAT, PREVIOUSLY AFFIRMED

EXAMINATION-IN-CHIEF BY MS WRIGHT

MS WRIGHT: Ms Hewat, could you please state your full name.

MS HEWAT: Elizabeth Claire Hewat.

MS WRIGHT: You've provided a statement to the Commission?

MS HEWAT: Correct.

MS WRIGHT: Commissioners, that's at tab 2 of your hearing folders.

Ms Hewat, You're the Chief Executive Officer of Allied Health Professions Australia?

MS HEWAT: Yes.

MS WRIGHT: AHPA for short, is that right?

MS HEWAT: That's correct.

MS WRIGHT: AHPA is the peak representative body for the allied health professions in Australia?

MS HEWAT: Yes, correct.

MS WRIGHT: It has 20 member associations each representing a specific allied health profession, is that so?

MS HEWAT: Correct.

MS WRIGHT: Are there also 12 affiliate member associations being groups that are aligned with allied health or are emerging professions?

MS HEWAT: Correct.

MS WRIGHT: Is an example of that the Hearing Aid Audiology Society of Australia?

MS HEWAT: Yes, it is.

MS WRIGHT: In terms of your experience, Ms Hewat, you're a trained dietician ---

MS HEWAT: I am.

MS WRIGHT: --- with over 30 years' experience in practice in a wide range of settings?

MS HEWAT: Correct.

MS WRIGHT: What is the size of the total allied health workforce in Australia?

MS HEWAT: The estimate is 200,000. It's only an estimate because the self-regulated professions, at this stage it's very difficult to collect the data. But we estimate 200,000 currently practising.

MS WRIGHT: There are both regulated or registered professions under the National Registration and Accreditation Scheme as well as, as you've said, self-regulated professions?

MS HEWAT: Correct.

MS WRIGHT: And allied health professionals as a whole represent almost a third of the country's healthcare workforce, is that the case?

MS HEWAT: It is.

MS WRIGHT: In terms of the registered professions, it might just assist those

watching if we were to identify what they are. Are there nine registered allied health professions?

MS HEWAT: It depends on your --- it depends on your definition but for us, there are physiotherapy, chiropractic, osteopathy, pharmacy, podiatry, occupational therapy, psychology.

MS WRIGHT: Optometrists.

MS HEWAT: That's right.

MS WRIGHT: And medical radiation, I think, is an allied ---

MS HEWAT: Yes, medical radiation.

MS WRIGHT: Is that right?

MS HEWAT: Yeah.

MS WRIGHT: Each of those registered professions has its own national board ---

MS HEWAT: Yes.

MS WRIGHT: --- which is responsible for overseeing education standards and the making of complaints against practitioners and verifying that practitioners are meeting or have met standards for practice, is that right?

MS HEWAT: Correct.

MS WRIGHT: And for the self-regulating professions, they have their own peak or professional associations which look after the accreditation process and set the professional standards?

MS HEWAT: Correct.

MS WRIGHT: Is there a difference in terms of education and training, is that difference in regulation relevant, in your view?

MS HEWAT: No. The regulation, whether self-regulated or under AHPRA is very robust, and they're very similar and the training is very similar.

MS WRIGHT: Each of the professions more or less determines its own training and education processes?

MS HEWAT: Yes.

MS WRIGHT: And content, is that right?

MS HEWAT: Yes, that's correct.

MS WRIGHT: In terms of what allied health is more broadly, they are health professions which are not part of the medical, dental and nursing professions, is that the case?

MS HEWAT: That is correct, yes.

MS WRIGHT: It's not in your statement, but I understand AHPA has developed it's own definition of what a health professional is and it might assist to identify that. It is a profession which has a direct patient care role, is that one aspect of the definition?

MS HEWAT: Yes, that is correct.

MS WRIGHT: Do all allied health professions, are they all engaged in frontline service delivery? In other words, they're all patient-facing?

MS HEWAT: All professions have members who are patient-facing but some have members who are not. But there must at least be a percentage of the profession who are patient-facing, and that's the majority of the professionals in those professions.

MS WRIGHT: To be an allied health profession, it must also be a profession which requires a university health science qualification at AQF level 7 or higher?

MS HEWAT: Correct.

MS WRIGHT: And a national professional organisation with a code of ethics and code of conduct?

MS HEWAT: Yes.

MS WRIGHT: As well as clearly articulated national entry level competency standards and assessment procedures, and a defined core scope of practice?

MS HEWAT: Correct.

CHAIR: Sorry. What is AQF level 7, for those of us unfamiliar?

MS HEWAT: AQF level 7 is a bachelor's degree or above. The majority of allied health professions are above.

CHAIR: In what sense above?

MS HEWAT: They are masters and some of them are PhD.

CHAIR: Thank you.

MS HEWAT: Entry-level qualified.

MS WRIGHT: There are clearly a very broad range of professions within the allied health professions. Could you just give us an overview of the types of work that allied health professionals do and the settings in which they work?

MS HEWAT: Yes, allied health professionals work extremely broadly across a wide range of settings. Of course, they're in health, in private and public hospitals, in community health, in private practice, in rehabilitation. But they also work in disability, they are the key professional workforce under the NDIS. They work in aged care, they work in corrections and community services. They work in education. They work in the military. Basically, almost anywhere you will find allied health professions undertaking a variety of roles.

They also work in policy management, in public health and preventative activities, in academia and research.

MS WRIGHT: You've identified in your statement to the Royal Commission that some of the professions work more directly in the disability field than others.

MS HEWAT: Yes.

MS WRIGHT: Professions having the largest proportion of workers who work with people with cognitive disabilities, do they include speech pathologists, occupational therapists, psychologists? What other professions would you identify?

MS HEWAT: They would be probably the main - actually doing the work with cognitive disability, but there would be smaller professions like music and art therapy who would work in that area. Also social work would be - would work there, particularly the mental health social workers, but you would also have smaller numbers in other professions such as physiotherapy, dietetics, exercise physiology. Most of the professions will work with people with cognitive disability at some stage, even if they're not actually providing specific disability services.

MS WRIGHT: Do you consider that there are core skills for treating people with cognitive disabilities that are common to and required by all of those allied health professionals?

MS HEWAT: Yes. There is a way of working with various groups, cognitive disability is one of them, and they would be core skills. There's core skills for physical disability, for mental health, for working with culturally and linguistically diverse communities. So all of those things have core skills.

MS WRIGHT: And in your view, is there a need for a national competency framework that identifies the specific competencies with --- that allied health

professionals should have regardless of the profession in which they are situated?

MS HEWAT: Yes, AHPA supports that.

MS WRIGHT: Your statement to the Royal Commission draws a distinction between health professionals who have a specific disability focus in their work and those who work in more mainstream settings in the health system, and who may only occasionally provide services to people with cognitive disability. Is that right?

MS HEWAT: Yes, correct.

MS WRIGHT: And AHPA proposes, in essence, competency frameworks calibrated to the level of risk of the particular professions and the particular risks that particular professions present to patients with cognitive disability. Could I ask you to speak to that?

MS HEWAT: Yes. Because if you are treating people specifically for cognitive disability, then there are --- obviously you're going to need a much higher skill level and you're going to need to be very well-equipped, and if it's something that you're doing all the time, you are going to have a different set of requirements to someone who is providing mainstream health services who only occasionally encounter somebody with cognitive disability. They are quite different levels of knowledge and skill and competence. There are obviously base levels of competency that everybody needs regardless of where they're working or what services they're providing, but then there needs to be a higher tier for those who are actually providing services to people with cognitive disability as a significant part of their workload.

MS WRIGHT: A proposition being tested in this hearing is the development of a competency framework, and I think you've been provided with those propositions. Perhaps if Proposition 1 could be placed on the screen, if possible.

Ms Hewat, that proposition puts forward a competency framework for health professionals which would include allied - relevant allied health professionals and it proposes consultation between all of the stakeholders, including people with disability and their family, support persons and stakeholders in the higher education system. Propositions 3 and 4, if they could be placed on the screen, they identify some of the areas that a competency framework could deal with, such as the importance of physical environments in Proposition 4, the role and legal requirements around adjustments, communication knowledge and skills and the supports a person with cognitive disability may use in decision-making.

Is it the case that all allied health workers would need these skills regardless of whether they are working in mainstream settings, as you've said, or are more patient-facing with a disability focus?

MS HEWAT: They would - they would need all of these working in a disability

focus at an extensive level. They would - people working occasionally with people with cognitive disability would need a clear awareness of these things and certainly need to know where to go for more information. It's really a case of making sure you know what you don't know and know where to go to find that information. Because people working in a generalist situation need to be across a wide range of things for a wide range of people and there are often similarities. You may need to make similar adjustments for people with mental health issues, there may be adjustments that need to be made for first Nations people. So there's a need for extensive information on each of those or a baseline understanding for those only working occasionally, and then a higher level for those working in the disability space is something that AHPA strongly advocates for.

MS WRIGHT: In your view, are there likely to be gaps in the training that's presently provided, whether to particular professions or overall in terms of some of these matters?

MS HEWAT: I think it will vary from profession to profession. Those professions that automatically work commonly in those disability spaces are likely to have higher levels of competency already and aspects of their training that are already there. Those who are more likely to work only occasionally in that space may not have that same level of training, but they may well have other approaches to dealing with diversity and dealing with complexities that can be adapted. So I think the important thing is to map what is already there.

A lot of allied health professions will already have at least some of this in their training and some more extensively than others.

MS WRIGHT: And would such a framework, if it was agreed by all the different stakeholders, be helpful, in your view, to the education providers in each profession in determining what to teach or in benchmarking or evaluating their existing programs?

MS HEWAT: Yes. A framework would certainly be of value to guide the development of those programs, or to map what is already there in their courses or might require adaption.

CHAIR: Ms Hewat, I think you said earlier in your view there are core requirements for allied health professionals who may be providing services to people with cognitive disability. Does your organisation set out anywhere what those core requirements are?

MS HEWAT: No, that is not our role. It is the role of the individual professions to set out the core requirements for their professions. We don't do that for anything. We are - our purpose is for advocacy and looking at common issues for allied health. But we would certainly encourage that everyone, and that would include medical and nursing, look at base - a similar baseline so that everybody is singing from the same song sheet, and we're not all learning different things.

CHAIR: Wouldn't this be a matter for advocacy by your organisation, it being a common issue?

MS HEWAT: We would advocate for it but we can't set the standards for the professions. We can only encourage.

CHAIR: And have you encouraged or advocated up to date?

MS HEWAT: We've been doing a lot of work in the NDIS providing feedback and advice on the development of their capability framework, which is something that would go across the professions. So we have been working with all our member organisations in providing feedback and advocacy in that area which brings all of those things together.

COMMISSIONER ATKINSON: Ms Hewat, you say in your statement that your organisation convenes a working group consisting of individuals from allied health profession, and you strongly recommend the involvement of this group in the development of a competency framework. Can you tell us about that group? Who is in that group? What professions are represented and what is its current role?

MS HEWAT: The current role of that group is to work with our policy manager. It initially started when the NDIS rolled out and it was to support the development of the NDIS and the work of allied health within the NDIS. It now has a broader disability focus and it brings together experts from the professions who do work in the disability area, professions such as speech pathology, occupational therapy, social work, physiotherapy, exercise physiology, music therapy, the range I talked about before. And they're all the experts from those professions. Understanding that those professions have a broad focus, they have experts in a whole range of areas, these are people who are very experienced and highly qualified in working in the disability space.

COMMISSIONER ATKINSON: And how many people are in that group?

MS HEWAT: I think currently it's about nine.

COMMISSIONER ATKINSON: Right. And you can provide the name of that group and the name of the people involved in that to us?

MS HEWAT: Certainly. It's the Disability Working Group. The names are not on the top of my head at the moment.

COMMISSIONER ATKINSON: Of course.

COMMISSIONER GALBALLY: Excuse me. Just following that question up from Commissioner Atkinson, can you also let us know how many people with disability leaders are on that group, you know, leadership people? Thank you.

MS HEWAT: Sorry, in terms - it is only representatives of the professions on that group. There's a representative from physio, a representative - but that is purely an internal group to AHPA.

COMMISSIONER GALBALLY: And those people aren't people with disabilities who are part of the professions?

MS HEWAT: No. Well, they could be, but that's not a requirement.

MS WRIGHT: And is it your evidence that that group, if there were to be a competency framework developed common to the allied health professions, that group would be involved in the development of the competency framework?

MS HEWAT: That group would certainly be the core group that would be providing feedback around the competency of the framework, yes.

MS WRIGHT: And would facilitate communication between the different allied health professions?

MS HEWAT: Yes, yes. They feedback to their individual professions and seek advice from their individual professions to inform all the work they do.

MS WRIGHT: Do you envisage that they could work with other stakeholders such as education providers, universities, for example?

MS HEWAT: Yes, of course.

MS WRIGHT: If I could ask you about some of the other propositions, Ms Hewat. Perhaps if Proposition 5 could be placed onscreen. That proposes that at appropriate points, training and education for health professionals should address the importance and skills necessary to work collaboratively with family, support people and advocates and professionals from various health and social disciplines. So it's looking at collaboration and a multidisciplinary team approach, working within a multidisciplinary team is a significant feature of allied health work, is it not?

MS HEWAT: It is. Very much so. It's not always possible but that's certainly the way that allied health prefers to work, particularly when you're dealing with complex situations.

MS WRIGHT: In your statement to the Commission in response to question 5, you identified that you were invited to present to the Commonwealth Department of Health targeted group discussion on curriculum development in healthcare for people with intellectual disability.

MS HEWAT: Yes.

MS WRIGHT: That was on 19 November last year?

MS HEWAT: Correct.

MS WRIGHT: Commissioners, the Department's summary of that discussion is at tab 43 of the hearing book. Ms Hewat, you presented on interdisciplinary education for health professionals, is that right?

MS HEWAT: I did.

MS WRIGHT: And you highlighted, according to the summary prepared by the Department, the need to look at training as a continuum, and you said that interprofessional education is essential to a more integrated multidisciplinary approach to healthcare for people with intellectual disability, and that any reforms to current curricula require interdisciplinary collaboration. Does that fairly encapsulate your views or some of the views that you put forward at that discussion?

MS HEWAT: Yes, it does because it promotes that more holistic approach to care and it also, as I said earlier, if you're looking at interdisciplinary education you're looking at providing all of the people who might be part of that multidisciplinary team, whether in disability services or not, with a similar baseline from which they're learning, rather than everybody coming from different points of view. So encouraging that interdisciplinary learning, that understanding, improves everybody's understanding of what other people in the team's roles are, how they can assist providing better services. So that sort of interdisciplinary, multidisciplinary training is of value.

MS WRIGHT: Could I invite your views on Proposition 5, and if you need it to be placed back up on the screen that can be done.

MS HEWAT: Please. Yes.

MS WRIGHT: Does it need to go further to encourage interdisciplinary collaboration in the setting of curricula, not merely that skills about working in a disciplinary - multidisciplinary team should be taught to students?

MS HEWAT: Yes, I think it does need to go further because one of the biggest issues, not just in disability but in health generally, is that often we learn in silos and when we get into the world we still think very much in our silos, and that's not necessarily very helpful for patients, clients, participants, consumers, whatever you want to call them. They want continuity of care, they want understanding, they want their team around them to all understand what's happening with them, and it's important to break down those silos, that there's a common understanding of what people are dealing with.

MS WRIGHT: If a competency framework were to be developed that is common to the allied health professions, does that call for that sort of collaboration and

interdisciplinary approach between the professions?

MS HEWAT: Absolutely.

MS WRIGHT: Is there anything else you would like to say about Proposition 5 while that's on the screen?

MS HEWAT: No, but I would add that a lot of that is in the curriculum for a lot of health professions already. We are expected to work not just in health but we are expected to work outside of health with people like the social disciplines, social services. That's something that is core to allied health work.

MS WRIGHT: And so it is the setting of the curricula in a more interdisciplinary way which may be the element that's missing?

MS HEWAT: I think so, yes.

MS WRIGHT: Could I also invite your comments on Proposition 7, if that could be put on the screen. That proposes mechanisms to enhanced funded supervised clinical placements to promote an enhanced learning and training in providing quality healthcare to people with cognitive disability, that that should be considered and scoped. What are the opportunities for clinical placements during primary allied health degrees, and who funds them?

MS HEWAT: By and large, allied health training is still done in the public hospital system. There is only limited opportunity for training outside of the public hospital system and certainly in the disability space, now that the disability services have largely been devolved to NDIS, the training opportunities have actually significantly reduced. There used to be a really good pipeline, there were well recognised services where people could undertake placements particularly if they had an interest in continuing in working in the disability services, but those teams and that funding has disappeared. So now that is quite problematic. There's --- the NDIS is a participant paying for their services. There's no stream of funding for student training within the NDIS, and anybody with disability outside the NDIS. It's serendipitous as to whether you get training or experience in your clinical placement. And private practice has great difficulty in - allied health private practitioners have great difficulty in taking students because it's time-consuming, it's expensive, and there is minimal or no support for it.

MS WRIGHT: What about post-graduation in early career development? Is there a mechanism for supervision and mentoring?

MS HEWAT: That, again, has diminished significantly with the changes from the disability being managed under the State systems to now being under NDIS and it's a similar issue. There used to be new graduate streams where there would be positions set aside available all the time for bringing new graduates through. That has disappeared and, again, it's ad hoc. Some of the bigger disability services can take

some early career allied health professionals but there's not the funding to support the supervision and mentoring within those services, and, again, in private practice, taking on a new graduate you take them on at your own expense. They basically - their productivity is clearly less, but that is something that a private practice would have to invest in of their own accord.

COMMISSIONER BENNETT: Can I ask a question. In the strategic plan that you provided to us, attached documents, under one allied health is to recognise the valuable role of government policy, there is under the third dot point a reference that says:

> *.... in partnership with the Australian Council of Deans .... [to seek] legislative change to permit students to undertake genuine active practicums in primary care settings.*

Is there a relationship to the point you're making at the moment, and what legislation is a barrier to there being practice in primary care settings and what difference would it create part of the pathway that you're talking about if - well, what legislation is and would it make a difference?

MS HEWAT: Absolutely. The main legislation that we're baulking about is the MBS and the DVA mirroring legislation where if you are seeing clients under DVA or MBS funding, that the student cannot provide services. They can sit with their hands behind their back and watch, but they are not allowed to touch the patient or undertake any care. That is not an effective way of training students. They actually need to get practice. And that's to do with the funding instrument. The funding instrument pays the practitioner and it does not allow for payment of students. So that is a real barrier, particularly --- either to people who use mostly DVA or MBS funding or even mixed funding because the student might be able to get hands-on practical experience for the privately-funded patient but would have to sit with their hands behind their back for a publicly-funded patient. So it's very complex.

COMMISSIONER BENNETT: So this is an item a doctor can seek to charge reimbursement from either the Medicare arrangements or through DVA, is that the legislation you're talking about?

MS HEWAT: That is the legislation I'm talking about, yes.

CHAIR: DVA, I assume, is Department of Veterans' Affairs, is it?

MS HEWAT: Apologies, yes, it is.

COMMISSIONER BENNETT: So in other health training doctors, general practitioners, are they able to access payment or is there an item for them to receive a payment?

MS HEWAT: Look, I can't speak on behalf of doctors. I believe the arrangement is

somewhat different for doctors, but certainly for allied health we've been told very clearly that the funding instrument only allows the practitioner to provide the service. It cannot be a student providing the service.

COMMISSIONER BENNETT: So that is the --- the consequence of that is less people willing to go in or not getting the experience in primary care and therefore perhaps enhancing the experience of on-the-ground practice with people with disability and their needs?

MS HEWAT: It's anyone under MBS or DVA, there will be all sorts of experiences, but the ability to get experience in primary care is significantly limited because of the funding instruments. There is also - that also can occur with other smaller funding instruments as well. So that does limit access to primary care, and then as I have described, the change in the funding mechanisms now with NDIS have significantly reduced the pipeline there as well. So it's a combination.

COMMISSIONER BENNETT: Thank you.

MS WRIGHT: Those are my questions, Commissioners.

CHAIR: Thank you. I will ask the Commissioners if they have any further questions for you starting with Commissioner Galbally.

COMMISSIONER GALBALLY: No further questions, thank you.

CHAIR: Commissioner Atkinson.

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner Bennett?

COMMISSIONER BENNETT: No.

CHAIR: Do any of the counsel or any of the legal practitioners who have leave to appear wish to ask Ms Hewat any questions?

MS FURNESS: No, thank you, Chair.

MR COSTELLO: No, thank you.

MS McMILLAN: No, thank you.

CHAIR: Thank you, Ms Hewat, for coming today to give evidence to the Royal Commission. We appreciate your assistance. Thank you.

MS HEWAT: Thank you.

THE WITNESS WITHDREW

MS WRIGHT: If we can have a five-minute adjournment to reconstitute the ---

CHAIR: Yes, we will adjourn for five minutes to allow the reconstitution of witnesses and screens.

ADJOURNED **[10.14†am]**

RESUMED **[10.18†am]**

CHAIR: Yes, Ms Eastman.

MS EASTMAN: Commissioners, our next panel is going to address the area of speech pathology and the Royal Commission will hear evidence from Ms Gail Mulcair, the CEO of Speech Pathology Australia. You will find a copy of her submission at Tab 12 of Tender Bundle C, and there are some annexures. Also joining Ms Mulcair on the panel is Stacey Baldac. She's the professional standards manager for Speech Pathology Australia, and Amy Fitzpatrick who is the senior adviser, disability for Speech Pathology Australia.

This panel will focus on Propositions 1, 2 and 5. Now, as at 1 January this year, there are 9,538 certified practising speech pathologists in Australia. Speech pathologists are university-trained allied health professionals with expert knowledge and skills to provide clinical services, consultation, education, prevention, advocacy and research for communication and swallowing.

Speech pathologists work across the lifespan, with infants, children, adolescents, adults and the elderly. Speech pathology is a self-regulated health profession, with Speech Pathology Australia acting as the self-regulatory body.

Quality and safety of speech pathology practice is regulated for members with requirements mirroring those required of registered professions which fall under the National Registration and Accreditation Scheme.

Speech Pathology Australia certifies the status of speech pathologists through a certified practising speech pathologist membership of the association. Speech Pathology Australia accredits 26 university entry-level training courses for speech pathologists in Australia and you have a copy of those universities in your materials.

Speech pathology also manages formal complaints process for the profession and can, if necessary, place sanctions on the practice of any member who demonstrates

that he or she has contravened the Association's code of ethics.

Now, before I ask some questions of the panellists, may I remind the Commissioners of evidence that you heard in February last year at Public Hearing 4, and you will recall Ms Jo Abi gave evidence in relation to her two sons who live with autism. She told you about her experience with navigating the health system and her experiences trying to find treatment and care for her sons, which included general practitioners, paediatricians, psychologists, speech pathologists and occupational therapists.

She shared her experiences of her interactions with speech pathologists and psychologists, and one issue that she identified was the significant cost for her and her family. You will recall her evidence is Exhibit 4.7 from Public Hearing 4. One of the issues she wanted to speak about was the lack of coordinated care and her battles between coordinating the care and communication between practitioners. I will play a video of the final closing remarks that Ms Abi made when she gave her evidence last year. Commissioners, please.

[VIDEO RECORDING PLAYED]

MS EASTMAN: I'm going to ask you in closing your evidence, thank you very much, for coming to give your evidence today to just read the final three paragraphs of your statement. So that starts at page 24, paragraph 116, if you want to read those final three paragraphs.

MS ABI: Okay. I have to be a doctor, a psychologist, a psychiatrist and a nurse to both of my boys. There aren't enough good practitioners who are affordable and available to help me with my sons. I feel like their human rights are being violated every day. They exist, we live in a society where everyone who exists should get what they need, but they don't. I'm reminded all the time that there are kids with more severe autism and severe mental illness but you can't compare hardship. Sometimes all I can see is that my boys have no hope of having a good life and no matter what I do I can't make that happen because no one's helping me. I'm an educated, media-savvy woman of resources and my kids are still not okay. When I do get help it's patchy, and so I don't have any trust. I don't trust the healthcare sector, I don't know if they're trained or not, but I'm tired of trying to figure it out. I can't fix the world, I'm too busy just trying to raise my boys.

MS EASTMAN: Ms Abi, thank you very much for giving evidence.

[VIDEO RECORDING ENDED]

MS EASTMAN: I think it cut off at giving her evidence. Commissioners, can I now introduce the panel members.

MS GAIL MULCAIR, PREVIOUSLY AFFIRMED

MS AMY FITZPATRICK, PREVIOUSLY AFFIRMED

MS STACEY BALDAC, PREVIOUSLY AFFIRMED

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS EASTMAN: Ms Mulcair, may I start with you. I can see you at the top of the screen. You are the CEO of Speech Pathology Australia and you are a speech pathologist by training, is that right?

MS MULCAIR: That's correct. Thank you, counsel, and thank you to the Commissioners for the opportunity to present.

Yes, I'm the Chief Executive Officer, Speech Pathology Australia. I've been in that role since 2004 and I originally trained as a speech pathologist and worked for many years as a speech pathologist in the area of adult rehabilitation, seeing people who had head injury and following head injury and stroke, had communication and cognitive and swallowing difficulties.

MS EASTMAN: And in your role as the CEO of Speech Pathology Australia, what are your responsibilities?

MS MULCAIR: My main responsibilities are providing governance support to our board of directors, ensuring the implementation of our strategic plan and leading policy and government relations activities, as well as providing oversight to the general financial management and operations of the Association and as you've said, counsel, some of the core functions of the association include setting the clinical and ethical standards for the profession, accrediting university training programs and supporting members' practice through clinical guidelines and continuing professional development.

MS EASTMAN: Can I turn now to you, Amy Fitzpatrick. I can see you on the screen. You're the senior adviser, disability, for Speech Pathology Australia, and this is a unique role, is it not? There's not another allied health professional group that has a senior adviser, disability. So could you tell us a little bit about your background and your role as an adviser with a specific focus on disability?

MS FITZPATRICK: Good morning, counsel. Good morning, everybody. So my role at the association is to have a particular focus on disability, so that might be

working with the professional education team to look at the needs in disability for our members in what training and professional development they might need, might be in working in writing submissions to the Royal Commission around healthcare or restrictive practices --- and I'm sure you've received many submissions from us recently --- it might be in meeting with other peak bodies to talk about similar issues that we might be experiencing across the sector or meeting with representatives from the NDIS to talk about things such as thin markets or difficulties that providers might be facing in the market. We might - I might be attending other meetings to talk about things such as what might be next for students in disability placements, sometimes I might meet with providers at hospitals about concepts such as disability liaison officers and how that might impact on communication access for people with disability. So it's a very rewarding and far-reaching role, I would say, but for me it's about how we might be embedding people with disability into every part of the community and how people with disability can get the services they need in every --- aspect of their life so that anywhere you go in the community, a person with disability is accessing the services from a speech pathologist and from other allied health professionals in everyday life.

MS EASTMAN: And your own background is - you are a trained speech pathologist, is that right?

MS FITZPATRICK: That's right. So at the moment I'm undertaking further study as well in health management and psychology, but I was trained as a speech pathologist graduating in 2003, yes, and my background is in working predominantly in paediatrics, so 0-18, in children who have a developmental disability, so mostly children with autism, children with syndromes such as Down syndrome or other development disabilities such as cerebral palsy, and anyone who has a need for speech pathologist services.

MS EASTMAN: Commissioner Galbally asked a question earlier this morning of Ms Hewat about whether any members of the advisory group or committee have lived experience of disability. You have lived experience of disability?

MS FITZPATRICK: I do, yes. And I was just speaking with Bronwyn Reid about that and I was wondering if that would come up because she asked me about a story that still haunts me. And I'm trying to not become emotional, but it's really difficult when you play videos like the one you were just playing, but I will try to contain myself. But I have a genetic syndrome that means that my mobility and my function is impaired, and my daughter also has the same genetic syndrome. So I wasn't aware of that condition until I had my daughter and some of the complications of that became apparent, so then I was diagnosed with that disability and she also has that disability. So we both have complicated healthcare needs and are both NDIS participants. But it's afforded me the opportunity to bring that passion and desire to see change to this role, which has been a really lovely opportunity. So I'm very passionate about that. But it has definitely been a whirlwind, yes.

MS EASTMAN: And you participated in the National Roadmap meeting to look at

issues around curriculum and the education on 19 November last year?

MS FITZPATRICK: Yes, that's right.

MS EASTMAN: I'm going to ask you some questions about that process shortly.

Stacey Baldac, can I turn to you. You're the Professional Standards Manager for Speech Pathology Australia and your role is directly concerned with accreditation standards and professional standards. Can you tell us about your background and your role, particularly in relation to the development and the implementation of accreditation standards?

MS BALDAC: Sure. Good morning, everyone. My background is as a speech pathologist, and I've worked across the lifespan throughout my career, primarily in neurological rehabilitation and then for a short period in community health. I've spent a considerable time in my career within higher education, and looking at accreditation and competency frameworks and adult education principles.

In terms of my role with the professional standards, so in 2018, Speech Pathology Australia undertook an initiative to review our standards and we developed and launched in 2020 the professional standards for speech pathologists in Australia and that document pertains to all practising speech pathologists at any time during points in their career. And the next process or the implementation of this is actually looking at what will be the actual required knowledge, skills and attributes and competencies that will be required at a graduate level. So we previously had a foundation document that highlighted our knowledge, skills, attributes and had competencies and measures against that, and now we're undertaking a large strategic project which involves consultation with a range of stakeholders in terms of them now looking at how that will actually be applied within the university context, how we will actually measure that and how do we ensure that our graduates meet our standards going forward.

MS EASTMAN: Now, I've asked you to consider all of the propositions but this morning we're going to focus on three of the propositions, and the Commissioners have got the very detailed response provided by Speech Pathology Australia as part of their documents which will be the evidence in this hearing.

So can I start with Proposition 1, which is the overarching competency framework and, Ms Mulcair, can I start with you. Is there anything that is now presently in place for Speech Pathology Australia that addresses competency in the context of a framework?

MS MULCAIR: As Stacey has outlined, we have a very detailed set of professional standards which are embedded in the expectations in terms of speech pathology training programs. Perhaps just to answer that, it might be useful if I give a bit more background around communication difficulties and the relationship of those with cognitive disabilities. And this may be very familiar to everyone but in terms of

communication needs or difficulties, they can arise from a range of conditions that may be present from birth, for example, Down syndrome or Autism Spectrum Disorder. They can emerge during early childhood, for example stuttering or developmental language disorder, or during adult years, for example, traumatic brain injury, strokes, head and neck cancers such as neuro-degenerative disorders such as motor neurone disease, or can be present in the elderly such as dementia, Alzheimer's and Parkinson's disease. Communication needs can arise due to difficulties with speech producing spoken language, understanding or using language, voice, fluency, stuttering, and pragmatics, which is the social use of language, or a combination of these areas with all of these areas having a relationship with cognitive abilities.

So this, in turn, requires that the undergraduate training of speech pathologists incorporates a sound understanding of cognitive skills which support communication and swallowing. So it's intrinsic in the training that speech pathologists have, and when speech pathologists refer to cognitive disability, this may relate from a developmental condition, for example, intellectual disability or an acquired condition, for example, dementia, or brain impairment following a traumatic head injury.

Cognitive abilities and communication are intrinsically linked with disorders of cognition such as attention, memory, executive functioning such as thinking and problem solving, all required for effective communication and also additionally contribute to a person being able to eat and drink safely.

In the context of this inquiry, we do acknowledge that cognitive disability is more usually referring to people with intellectual disability, but we would propose that cognitive disability, as I've indicated, is intrinsic to all aspects of communication across the whole lifespan. And the nature of communication, swallowing difficulties, exposes individuals to a higher potential for abuse, neglect and mistreatment but also affects their ability to voice their concerns to self-advocate and disclose or report harm done to them by another person. So it's very well-aligned with the remit of this inquiry.

To answer your question, to come back to your question, from the point of view of a specific framework, I will defer to Stacey to answer that in a bit more detail, but there's not a framework in terms of cognitive disability competency per se, but it is embedded in the training program. It's embedded in the expectations of our speech pathology training programs, that they equip students and prepare them to be ready for practice across the whole areas of communication and swallowing difficulties which, as I've said, is intrinsic to or requires that cognitive abilities are considered in all contexts.

MS EASTMAN: Ms Baldac, do you want to add anything in terms of the work you do at Speech Pathology Australia on the accreditation standards and professional standards generally?

MS BALDAC: Sure. I guess just to put into context, our accreditation process looks

at outcomes or outputs, so I'm very mindful that accreditation models might look at inputs in terms of what are the undergraduates actually being taught and looking at specifics with regards to content and references, and then there are output models which are looking at what are the capabilities or the competencies that the graduates can actually demonstrate.

The Speech Pathology Australia model has a focus on inputs when it's relevant to quality outputs, but we primarily assess a university looking at their high-level assessments, and looking at the outcomes and capabilities of students.

MS EASTMAN: In saying that, just there, does any of that assessment also look at whether or not the students undertake clinical placements and have practical training?

MS BALDAC: Yes, yes. So the onus is on the university to demonstrate to Speech Pathology Australia how they prepare their graduates and how they can provide evidence of their competencies and that's a combination of clinical placement experiences and robust, rigorous assessments similar to OSCEs or vivas, and they're usually at what we call an entry level which is an integrated holistic assessment. So we're not just looking at assessments of a skill or a task, we're looking at how they actually apply those skills and tasks in a holistic manner. And to do that, the students typically have to show demonstration of principles of the international classification of ICF, and so within that they're having to report in terms of how they appreciate and understand a person's needs and their goals and understand how cognitive abilities will impact on their ability to undertake assessment therapy or engage with carers.

So within our specific accreditation guidelines, it clearly indicates universities must report and show evidence of how their graduates are able to build in their understanding of development and cognitive abilities across the lifespan for all of their clients. So it's not pulled out in pieces, it's actually, in every interaction, in every assessment there must be an application of graduates being able to demonstrate how they've understood the client's needs from a cognitive perspective and how they've built that into their assessment or therapy or whatever the assessment task involved.

MS EASTMAN: So is the view of Speech Pathology Australia that you are supportive of a competency framework?

MS BALDAC: We're definitely supportive in principle of a competency framework. Currently, our process is such that it is integrated through our accreditation requirements and I guess we just have some - we feel a competency framework will help guide, give some guidance to universities, guidance to speech pathologists, guidance to other professionals. I guess it's about how it will be implemented. And I say that in terms of accreditation processes are different across the health professions. So if you have a health profession that looks at an input-based model and is just looking at what goes into the curriculum with respect to knowledge, then

you're not necessarily then resulting in changing behaviour and capabilities. So you would hope that a competency framework is developed so that you're looking at knowledge skills but you're also looking at capabilities, values and beliefs within that.

MS EASTMAN: I ask you, because you've used both "competency" and "capability", and sometimes those expressions seem to be interchangeable but at other times they're looking at quite specific, different issues. And you and Ms Fitzpatrick have drawn to the Royal Commission's attention the "Allied health capability framework: Disability and complex support needs" recently issued by the State of Victoria. Commissioners, you have a copy of this document behind Tab 9 in the hearing bundle for today. I don't want to take you through the whole of that document, but could I ask either Ms Fitzpatrick or Ms Baldac, do you want to comment on the issues that arise around capability and the extent to which that sits with the competency framework and any experience that you've had with the development of the Victorian allied health capability framework.

MS BALDAC: I think Amy would need to speak to the development of the framework, but I guess in terms of when I refer to competency in the context of our accreditation, we're referring to measurable, observable behaviours. And typically, capabilities is something that is still growing and developing, so you might have skills and knowledge in a certain area, but you need to keep improving your skills and knowledge because situations change and that might be with respect to your understanding how to respond to cognitive abilities or to respond to Aboriginal and Torres Strait Islander cultures. So competencies in this context, in terms of accreditation, refers to measurable, observable events with key criteria that you can tick off against.

MS EASTMAN: Ms Fitzpatrick?

MS FITZPATRICK: I think Gail and Stacey can confirm this, but from my point of view, for speech pathologists particularly, it's our position that every speech pathologist, when they graduate, they are competent and capable to work with every person with a cognitive disability and that's something that we feel very strongly about. But we would like them to keep demonstrating their capability over time by continuing their professional development and continuing to have supervision in place so that's what we would like to see when they're demonstrating their certified status.

So when we're looking at something like the allied health capability framework that you have a copy of, we really like this kind of framework because it gives that, you know, an additional kind of training package that can be used in that interdisciplinary practice so that you can work together collaboratively as a team, and it gives you that resource that you can take as part of your professional education that really shows you the capabilities that you might not have learnt in university because there are different university programs but it's something that's agreed upon for that extra education.

So this is something that I think is a really good resource that the Commission could have a look at to see the kind of skills that we're saying would be over and above what we're teaching at a university level, but are the kind of ideas that we would like to see intrinsic in what people with disability would like to experience in a healthcare setting. So that's the kind of example of something that's common to all of the healthcare professionals working with people with disability, but wouldn't necessarily need to be embedded in that undergraduate level. So I think that that's just an example of something that has been developed already that would be a good example of what could work well.

MS MULCAIR: If I could perhaps add something, counsel, if that's okay.

MS EASTMAN: Of course.

MS MULCAIR: As we've said, we certainly have a very strong agreement in principle to a cognitive framework, a competency framework in the area of cognitive disability. Whether that suits our profession, given, as we've said, we believe that there is a very sound and robust knowledge of communication and cognitive disability intrinsic to the work that speech pathologists do, but that may not be the case for all health professions, and so we would see that is really essential, that all health professionals have an understanding of working with people with cognitive disability, understand their specific needs, and have the strategies and the capability to be able to engage people with cognitive disability in decision-making around their healthcare and in being able to fully participate in determining their healthcare needs.

So for other professions, we would see this as being very useful. For our own profession, we would see this as something that would be of additional benefit and potentially would contribute to the course, the curriculum design and content for speech pathology programs, but not necessarily be a specific competency framework that needs to be part of our accreditation processes at undergraduate level.

I think it will be useful to also explore the difference, the potential difference between what might be useful at undergraduate level versus what is useful for a postgraduate level in terms of that continuing professional development that all health professionals should be undertaking, and whether something of this nature actually sits well as some additional modules or additional training resources that are open to all health professionals to be able to undertake.

MS EASTMAN: I wanted to turn now to Proposition 2, and we might put that up on the screen. That is a proposition that calls for the active involvement of people with cognitive disability in the development and evaluation, the delivery of training and education. And I wanted to ask you --- and whoever would like to take the question, let me know, but --- does speech pathology work in conjunction with people with cognitive disability in the development of the curriculum that it accredits? Accepting that the universities, of course, develop the curriculum for the undergraduate students, does the role that you have in accrediting look at whether or not that

development has occurred in conjunction with people with cognitive disability, and to what extent do people with cognitive disability participate in the processes? Who want to say take that question?

MS BALDAC: It's Stacey here, I probably should take this question. In terms of our accreditation process we look for that the curricula is reviewed and has input from stakeholders and they can include local community members, consumers of services, and speech pathologists that might be working in their context. We do not have specifics, though, with regards to the curriculum review should include people with cognitive disability. It just has a broader stakeholder and consumer lens. We do have a requirement around --- university curricula is designed or in consultation with Aboriginal and Torres Strait Islander peoples.

MS EASTMAN: Is there a reason why there hasn't been a focus on people with cognitive disability being involved in the development or review of curriculum and then broader training?

MS BALDAC: There's no specific reason. Typically the university process for the development of a curriculum that is sort of monitored by TEQSA, so the tertiary education - I'm forgetting the whole acronym --- so if a university is wanting to develop a curriculum then they need to follow the guidelines as per the university and TEQSA, and that usually stipulates the range of people that need to be at the table for the development.

And then the review process as well, TEQSA also indicates who needs to be at the table with respect to the review, and it has typically consumers or stakeholders but it doesn't specify individuals with cognitive disability.

MS EASTMAN: So individuals with cognitive disability may be picked up if they're consumers, would that be the place?

MS BALDAC: Yes, they may be picked up.

MS EASTMAN: But not specifically referred to as a particular cohort of consumers for whom there should be some consultation and some cooperation, is that right?

MS BALDAC: No, that's right. So for Speech Pathology Australia's purposes only, for our university accreditation, we ask universities to demonstrate how they're engaging with Aboriginal and Torres Strait Islander peoples, and so that's the only group that we specify that we are seeking input into their curriculum.

MS EASTMAN: Do you accept that there would be value in also including people with cognitive disability as people with whom there should be consultation?

MS BALDAC: Definitely, and I can't recall every university context, but most universities try and build into their curricula opportunities to have access to the lived experience of speech pathology services. So it's not a specific requirement within

our accreditation process, but given that the university's programs are trying to ensure that students understand the impact of disability and communication needs, many of their assessments, many of their experiences are based on real life client information, and so that's typically what's embedded into their curricula.

CHAIR: Ms Baldac, can I try to understand a little better than I do at the moment, the precise relationship between university curricula and your accreditation process. How does that work?

MS BALDAC: So universities are free to develop curricula based on current teaching processes, or the pedagogy or the position of the university.

CHAIR: I understand they're autonomous, but I'm trying to understand where your accreditation process fits in.

MS BALDAC: Sure. So in terms of for graduates of a university to become eligible for speech pathology membership, they need to be accredited by Speech Pathology Australia. So our process commences when a university starts taking students and we accredit the course prior to the first cohort of graduates.

CHAIR: I understand, but I'm trying to ascertain what criteria you apply. If universities are autonomous and you have no authority over them, what is it that you are doing to ensure that the accreditation process serves the purposes that you're seeking to achieve?

MS BALDAC: Sure. So our foundation tool or document that the universities must demonstrate is our competency-based occupational standards, often referred to as CBOS. The universities have to demonstrate how students meet the requirements within CBOS, and they do that via a portfolio of evidence demonstrating the clinical placements that students attend, the types of assessments and provide details on the assessment task, the assessment rubrics and so we have a panel of academics to review that content to determine if the students are demonstrating the required competencies as per CBOS.

CHAIR: So in practice, this set of competencies is something that university courses have to adhere to because if they don't, their graduates won't be accredited or registered with your organisation?

MS BALDAC: That's correct.

CHAIR: Does it follow, then, that you do have the authority to do the sorts of things that Ms Eastman is putting to you in terms of the universities developing their curricula in, for example, in consultation with people with disability?

MS BALDAC: Yes, yes, we can make requirements in that respect.

CHAIR: So universities, in practice, not quite as autonomous as all that.

MS BALDAC: No, they're probably autonomous in determining their pedagogy, but they are required to have certain inputs and definite outputs.

CHAIR: There's nothing unusual about this. It's exactly what happens with law schools.

MS MULCAIR: And it links in with the fact that Speech Pathology Australia is the regulating body for the profession. As we said earlier, we're the self-regulating professional peak body for the profession and our profession speech pathology is not covered under AHPRA, it's not a registered profession, and so as Ms Baldac has indicated, for a graduating speech pathologist to become a certified practising speech pathologist, they must be successfully graduated from a university program that we have accredited.

CHAIR: And one significance, or one feature of significance if a person is a registered speech pathologist with your organisation, is that there are certain entitlements as far as the Medical Benefits Schedule is concerned. Can you just explain that briefly? What is the benefit to a registered speech pathologist in that respect?

MS MULCAIR: So a certified practising speech pathologist has met the required requirements in terms of their undergraduate training, and they have also - they must demonstrate on an ongoing basis that they meet our recency of practice as well as ---

CHAIR: Sorry, I may not have made myself clear. I'm wanting to know what the benefit is to the registered speech pathologist in having an entitlement of some kind under the MBS. I'm just trying to understand what benefits.

MS MULCAIR: Yes, sorry, yes, no, I understood your question, sorry, I was leading to that. So there are many funding bodies, including Medicare, so the MBS schedule, including NDIS, including DVA, Work Cover schemes, TAC, who all require a speech pathologist to be a certified practising speech pathologist. It's the way in which they can determine quality and appropriate qualifications and skills. So that is a benefit, and for people working - for speech pathologists working in private practice, it would be very difficult to be working in private practice if you were not a certified practising speech pathologist because your clients would not be able to receive funding or rebates through those schemes.

CHAIR: Yes, thank you very much.

MS EASTMAN: Could I briefly turn to Proposition 5, which is collaboration and a multidisciplinary approach and Proposition 5 addresses training and education for health professionals being something that should address the importance and skills necessary to work collaboratively with families, support people, and advocates, professionals from various health and other social disciplines. We have partly touched on it. The first question I want to ask you is whether our description

"multidisciplinary" is the correct or preferable way of describing the approach.

I think, Ms Fitzpatrick, you've got a view on whether "multidisciplinary" is the right expression.

MS FITZPATRICK: Actually, that's Ms Baldac who wants to explain about that.

MS EASTMAN: Okay.

MS BALDAC: I appreciated that it's been written in with good intent in terms of people working together for the benefit of the client's needs. In terms of supporting collaboration, “interprofessional practice” would be the preferred term for Speech Pathology Australia, and interprofessional practice is the terminology that the World Health Organization also utilises with respect to supporting collaboration, improving quality and client outcomes.

MS EASTMAN: And I understand that in terms of an interprofessional practice and collaboration, this is something that Speech Pathology Australia strongly supports?

MS BALDAC: Definitely. And certainly interprofessional practice is one of our criteria into our accreditation requirements as well.

MS EASTMAN: Is there any particular advice that you can give to the Royal Commission about how you go about achieving an effective interprofessional practice to support care and treat people with cognitive disability? There's a very large question to ask you to answer in less than five minutes.

MS BALDAC: If you refer to the literature interprofessional practice barriers come at system organisational and individual levels, and so at the moment health practitioners, the majority of them wish to work in an interprofessional way but there are system barriers because funding models do not support or fund for collaboration and joint time. They're often funded just for your time with the client. So there's big system issues with funding. At an organisational level, there are challenges with respect to how teams are structured because of funding and how it's supported, and so funding often gets separated.

But from an educational perspective, there are opportunities at an undergraduate level to build that into courses, but that requires collaboration across all the health disciplines, and that's not just in the academic context, there also needs to be collaboration for placements. So many students don't really realise the benefit of interprofessional practice until they're actually with real clients in their practice placements working with others, and so alignment is often a real challenge for clinical placements. The physiotherapists come in January, the occupational therapists come in February, or they come on different days, and they all have specific criteria that they need to tick off to get through the placement, but they need to all have a common goal of interprofessional practice, and there should be opportunities built in at the academic, in the university context, and then in the

clinical placement context.

Now, I am aware that health professions associate accreditation councils, so they're registered professions, they're collaborative of similar positions to mine, are currently trying to look at some key common interprofessional criteria, or competencies, to build into accreditation processes. And I'm also very mindful that the COAG review of accreditation systems also suggested that interprofessional practice should be built into accreditation processes.

So there's an opportunity here for us to make significant change across all professions if there was a drive, a push, to say build it into undergraduate training but it's supported in academic and clinical placement opportunities.

MS EASTMAN: Where does the drive or push have to come from? Is it government? Is it universities? Is it the professional bodies?

MS BALDAC: I think it needs to be all. Because there is no point advocating at a university level, "You must work in an interprofessional way" and then you go to a clinical placement or experience and they're only funded for multidisciplinary. If they cannot actually realise it or see it in practice then it's hard to go forth and say "Let's model it" if you're not funded to do it, if you just go, "No, you go in on your own". We want to have models where one or two professionals go in and see a person at one time, reduce duplication of asking questions. There needs to be trust built amongst professionals so that you can share information and know that it's accurate, and that you can build upon that. So it's a multilevel response.

MS EASTMAN: Who should bear the responsibility of implementing the type of arrangement that you've just described?

MS BALDAC: Well, I think from a university perspective, we know this reflects best practice and so this is what quality - you know, to support quality outcomes. So universities should be saying we want to provide an evidence-based curriculum, so they should be building it in. Many health providers are striving to provide interprofessional practice but their barriers are often funding, their barriers are funding for their practitioners but also for their infrastructure. If you can't actually have teams that sit alongside each other or have opportunities to talk there are barriers. But if the government was to drive - change funding models to say we want interprofessional practice models, not multidisciplinary models and so we factor in opportunities for collaboration, team planning, you know, meeting with clients, determining joint needs, then that's going to facilitate a big shift in how we can service our clients.

MS MULCAIR: I support that. It definitely needs to be supported through the funding model. Separately, I'm involved in the primary health reform ten-year plan steering group and funding models is something that is being explored and considered in terms of how that will support equitable access to a wider range of allied health professionals and interdisciplinary practices, as Stacey has described,

needs to be supported by appropriate funding rather than the funding that we might have at the moment with the NDIS which is really a fee for service, single service with a single person funding arrangement.

MS EASTMAN: Commissioners, this has been just really an introduction to the material provided by our witnesses from Speech Pathology Australia today. I've concluded the questions I need to ask. Are there any questions from the Commissioners?

CHAIR: Let me ask Commissioner Galbally first.

COMMISSIONER GALBALLY: No further questions, thank you.

CHAIR: Thank you. Commissioner Atkinson?

QUESTIONS BY THE COMMISSION

COMMISSIONER ATKINSON: You spoke, and I'm not quite sure who can answer this question, but you spoke about your capacity as an accrediting body to influence what happens in universities. Would it make a difference if your profession was registered, and what capacity does AHPRA have to influence what happens in universities for health practitioners that are registered?

MS MULCAIR: I think our processes are very similar to the registered professions in terms of our standards. We have mirrored the standards in terms of self-regulation on the standards that AHPRA sets for registered professions. I don't believe that being a registered profession would give us a different relationship with the universities. There are different benefits of the profession being registered, but in terms of the accreditation process, I would argue that we are probably similar to the registered professions in the relationship between our accreditation processes and the university curriculum development. Stacey may have a view in terms of the relationship that she has with a number of the similar accrediting personnel of the registered professions.

MS BALDAC: I think it's in terms of if we were registered we'd have greater access to the table, when some decisions are made across different perspectives where we often hear of events that are for registered professions to provide advice, and we're often going, "can we come too?", which is a bit of a challenge in terms of piggybacking or trying to get in on the scene. So I think there would be benefits about being at the table, but I don't think it would necessarily change our capacity to change our standards. I think we have probably a better window to change our standards given that we are self-regulating.

CHAIR: How many universities have speech pathology courses?

MS BALDAC: At the moment there's about 26 universities and more preparing courses as we speak.

CHAIR: Of the 9,000-odd accredited speech pathologists, are any leftover from the time when there weren't speech pathology courses at universities?

MS MULCAIR: No, they would all be appropriately qualified and meet our requirements in terms of Australian-based qualifications. We also have a process for assessing people with overseas qualifications and people with overseas qualifications, again, must be able to demonstrate that they meet our standards for practising in the Australian context.

CHAIR: And how do you deal with complaints against speech pathologists?

MS MULCAIR: We have a code of ethics which applies to all of our members. We have an ethics board, and where we receive complaints, we have a very formal and documented process of investigating complaints. We would establish an investigation panel and the panel would explore the complaints both with the complainant and the respondent and then consider the case and make recommendations to our board. We have ---

CHAIR: How many determinations would have been made by such a panel over the last 12 months, for example?

MS MULCAIR: I would have to take that on notice but it would probably be around - I'm just going to guess -

CHAIR: Don't guess, that's fine.

MS MULCAIR: It would be about 12 per annum, but there has been some increase in recent years. That's formal complaints. We do certainly consider any queries that we receive from the public, or from other speech pathologists, that are expressing concern around the practice of a speech pathologist and we have a process for exploring that particular concern. So there are a number of informal queries that don't reach a formal complaint process. But I will take that on notice and get back to you with the formal data.

CHAIR: Thank you. Finally, I would like to give Ms Fitzpatrick an opportunity to tell the Commissioners what you would like to see implemented in order to improve the position, if it needs improving, of the relationship between speech pathologists and people with cognitive disability.

MS FITZPATRICK: Thank you. I was wondering if I would get the chance to give you my bucket list.

CHAIR: Now's the chance!

MS FITZPATRICK: Absolutely, thank you. I was just thinking, while Ms Baldac was speaking, about an example in practical terms because I'm a very practical person of what it would look like, and I was thinking, wouldn't it be lovely if, for example, an occupational therapist, while they were in university, was able to learn what a pain scale is or what a visual support is, and what a communication device is, and how that would look when one of their clients or a person with disability is in hospital, and learn how to do that and how to work with a speech pathologist so that when they graduate as an occupational therapist or a psychologist, they know already what it is like to work with someone who is non-speaking so that when they are working in a hospital already as a new graduate, they don't need to learn that from a speech pathologist or go to Dr Google or their professional association because they already have those skills. So I was just thinking that would be lovely.

And I was thinking as well, so a story from my own life is that when I go to hospital, which is very often, as I'm packing my bag I pack my cheat sheet of what my syndrome is, I prepare which vein I know that I'm going to say is the best vein to draw blood from and put the catheter in - sorry, the cannular in, I know how to say this is where my - what my blood pressure will be, so this is when you need to worry and this is when you don't, and I need to prepare that because I know I will be tired because I'm fasting, and I was just thinking, imagine if somebody who is non-speaking and uses a communication device or somebody, an autistic person who needs a sensory room that's quite calm because they have an aversion to bright lights or noises, imagine if they were able to go to hospital themselves without a support worker or without their family member or partner because they've been able to be prepared for that experience before going to hospital because they are able to call and say, "This is what I need". Imagine if they were able to go to hospital by themselves in a public hospital because there's a disability liaison officer or there's a speech pathologist who is working with them and they can write that up on their communication device or in Easy English beforehand, and they can go by themselves because they have their choice and control, you know, as a participating person in society. That's just what I would like to see, because there's enough funding through the NDIS or through the health system for the person's speech pathologist to speak to a speech pathologist or a disability liaison officer in the community, or the GP has worked with the person through the Medicare system because the Medicare system has adequate allied health services and time for the GP to spend time coaching that person to ask what they need. They can go to hospital, have that procedure, and the person's family is at home because the person with disability can go to the hospital by themselves.

I know that's utopia, but to me that sounds doable, and if that can be done, then I'm out of a job and I can stay home with my daughter! So that would be wonderful and I just think that that shouldn't really be a dream because that would just be lovely, and then speech pathologists don't have to stay up all night writing these kind of plans for people with disability to, you know, access the healthcare that they need because they're getting paid to do it during work time.

Yeah, that's what I would like to see, I guess.

CHAIR: Thank you very much. Thank you, Ms Fitzpatrick.

Just before we conclude, I will ask Mr Costello, Ms Furness or Ms McMillan if they have any questions to ask of the panel?

MR COSTELLO: No.

MS FURNESS: No, thank you.

CHAIR: If not, then thank you very much to each of you, Ms Mulcair, Ms Baldac and Ms Fitzpatrick for coming and giving evidence to the Commission. We appreciate your evidence very much. Thank you for the session.

MS MULCAIR: We appreciate the time.

THE WITNESSES WITHDREW

MS EASTMAN: If we could adjourn now for a brief morning tea of 15 minutes.

CHAIR: We shall resume at 11:30 Sydney time, 10:30 Brisbane time.

ADJOURNED **[11.15 AM]**

RESUMED **[11.29 AM]**

CHAIR: Yes, Ms Eastman.

MS EASTMAN: Thank you, Commissioners. The next panel is the pharmacy panel and we'll have four members of the panel and I will introduce them shortly.

I want to take the Commissioners back to some evidence that you heard at Public Hearing 6, and you may recall Dr Manya Angley who gave evidence at that hearing. She's a consultant pharmacist and part of her work is to conduct home medicine reviews and deliver quality use of medical and management reviews. She told you, at Public Hearing 6, this: both the community and consultant pharmacists also have an important role in promoting the appropriate use of psychotropic medication, particularly where the monitoring and management of medicines by prescribing practitioners fall short. She said services provided for individuals and families impacted by intellectual disability sit across a broad range of sectors including but not limited to health, education, disability services and the parent consumer sectors. She said quality use of medicines doesn't only fall in the realm of the health sector,

especially with respect to quality use of psychotropics which are often used to manage behaviour in the home, school, or care settings. She said:

> *It is vital that each sector is recognised for their unique contribution but also that they work together to ensure the best outcome for those impacted. Pharmacists can play a key role in gathering medication-related information and the highly complex psycho social issues that surround medication use.*

Commissioners, you will also recall the evidence presented at Public Hearing 6 by Ms Paula McGowan. She's Oliver's mother. Oliver died when he was 18 years old in November 2016. Oliver had been treated at several hospitals for seizures. Paula McGowan and her husband firmly believe that if Oliver had not had the labels autism and intellectual disability attached to him, he would not have been prescribed certain psychotropic medications, and the catastrophic impact on him and his family would not have occurred.

Commissioners, you will recall that Oliver had an adverse reaction to - I knew I was going to get this wrong - Olanzapine and developed NMS. Ms McGowan took a petition to the UK Parliament demanding that health practitioners have better training on intellectual disability and autism, and she wanted the training to be mandatory across all health and social care individuals. She was successful in that endeavour, and this work has resulted in the introduction of the Oliver McGowan Mandatory Training in Learning Disability and Autism courses for health and social care staff.

You will also recall that she told you about the organisation STOMP which is an advocacy group that started in the UK in 2016 to stop the overuse of psychotropic medication to manage the behaviour of people with learning disabilities. I want to play a short part of Paula McGowan's evidence that she gave at Public Hearing 6.

[VIDEO RECORDING PLAYED]

MS McGOWAN: I am seeing children who, in my opinion, are overmedicated. The children's reactions are very slow. They appear disengaged and are not always able to interact with their peers. There are attitudinal problems with the use of medication and many people do not seem to be aware of alternatives such as behaviour support or management techniques. When I have talked to members of the public in Australia about this issue, particularly people from older generations, they don't seem to know what to do or are bound to medicate people what they have what they perceive medications that challenge. Greater awareness can highlight the inequalities in health and social care but people with intellectual disability and autism face in Australia. Awareness will also tell us - help to tell us just how many people are dying premature and preventible deaths. It is important that health professionals, social care and disability support workers all have appropriate training in assisting people with an intellectual disability and autism.

Australia should also have standardised mandatory training in relation to these issues. As I have stated above, when everybody has been given the same training, this allows for everyone to be evaluated, assessed and monitored in respect to this issue. I believe the Oliver McGowan Mandatory Training in Learning Disability and Autism could and should be adopted here in Australia to support clinicians in gaining understanding of alternatives to psychotropic medications, of how to make reasonable adjustments and of appropriate behaviour management. Communication with people with intellectual disability and their families about their health and treatment is very important.

Some of the health professionals who treated my son did not properly listen to our or our son's views regarding the use of psychotropic medication. It is vital that the patient is kept at the heart of all decision-making, giving them an equal say in their care: their care and treatment that belongs to them. Health practitioners who are supporting and treating people who have a learning disability and/or autism should, A, ask people with a learning disability, autism or both, their families and carers for their opinions and concerns about their treatments. B, listen: listen to all involved and show respect for those opinions and concerns. And, C, do something about it and work in partnership with them.

They should treat all patients in a way that they should wish to be treated themselves with respect and dignity. They must remember that the care that they are giving should always be in partnership with the patient and, where appropriate, with their families and carers.

They must also understand how to make reasonable adjustments and how to modify their language and communication. They must ensure that their body language is non-threatening, not invading the space of the patient with intellectual disability, not standing over them. They must be careful not to use a lot of medical jargon. They need to be aware that their patient may need time to process what is being said and they need information to be repeated. This does not mean talking to patients as though they are children.

In conclusion, ultimately, however, there must be government support and commitment to addressing these problems. The government must start taking these issues seriously from start to finish. I have observed that Australia is a very proud country which says that it treats its citizens with fairness. However, I don't think this is always the case where people with intellectual disability and/or autism are concerned. The work of researchers like Professor Julian Trollor show that they are not always able to have equal health outcomes as the rest of the general public.

It is not fair or right that they are dying younger than their peers. It is not fair that professionals, clinicians, are not given the education and skills required to help them enable patients with intellectual disability and autism to have better healthcare outcomes.

[VIDEO RECORDING ENDED]

PROFESSOR BRUCE ABERNETHY, PREVIOUSLY AFFIRMED

MS BRONWYN CLARK, PREVIOUSLY SWORN

MR GRANT MARTIN, PREVIOUSLY AFFIRMED

MR BRETT SIMMONDS, PREVIOUSLY AFFIRMED

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS EASTMAN: Commissioners, this panel will, and we'll try in the time available, cover Propositions 1, 3, 5, and 11. Can I start by introducing the members of the panel.

Professor Abernethy, may I start with you. You are Bruce Abernethy?

PROFESSOR ABERNETHY: Yes.

MS EASTMAN: And you are the Executive Dean of the Faculty of Health and Behavioural Sciences at the University of Queensland.

PROFESSOR ABERNETHY: That's correct.

MS EASTMAN: And you provided the Royal Commission with a statement that sets out the undergraduate courses for pharmacy, psychology and speech pathology offered at the University of Queensland?

PROFESSOR ABERNETHY: That's correct.

CHAIR: Sorry to interrupt, Professor Abernethy, but I'm not sure we're hearing you properly. Could you give us a complete sentence and then we'll be able to see or hear whether we can follow you.

PROFESSOR ABERNETHY: Yeah, sure. I'm Bruce Abernethy, I'm the Executive Dean of the Faculty of Health and Behavioural Sciences at the University of Queensland, and pharmacy is one of six schools within our faculty.

CHAIR: Yes, we can hear you. Thank you.

MS EASTMAN: The Commissioners have got the benefit of a very comprehensive statement, including the tables that set out the content concerning people with cognitive disability in each of the courses that you've described, but could I just ask in summary, from the perspective of the University of Queensland, is priority given to the students learning and understanding about the importance of health care for people with cognitive disability? And if so, how is that done?

PROFESSOR ABERNETHY: It's certainly an important consideration in our - in each of the curricula. If you're talking about pharmacy in particular, perhaps I can highlight that by way of example, where, you know, increasingly we're wanting to have an approach which is very much a person-centred approach to the delivery of programs, and that's best exemplified by having case studies, hearing the intimate stories of people who are living with intellectual disability and that of their families, so that things like medication prescription can be put in an appropriate context. The same kind of issues would apply if we're talking about an allied health program or psychology program.

MS EASTMAN: I'll come back to you shortly when we delve into Proposition 1, the competency framework, but can I introduce the other members of the panel.

Ms Clark, may I start with you. You're the Chief Executive Officer of the Australian Pharmacy Council. Can you tell the Royal Commission what is the Australian Pharmacy Council and what are your particular responsibilities?

MS CLARK: Thank you. The Australian Pharmacy Council is the accreditation authority for pharmacy education in Australia. We work within the National Accreditation and Registration Scheme, and my responsibilities are to ensure that we undertake our accreditation functions of health professions programs and pharmacy and assessment of pharmacists to the standards that are expected of the community for the safe and socially accountable care of people in Australia.

MS EASTMAN: You've also provided the Royal Commission with a detailed statement. To what extent does the care of people with cognitive disability form part of your work and the responsibilities of the Australian Pharmacy Council?

MS CLARK: So our accreditation standards are the platform and the base standards that education is set against in Australia, and in the most recent review we have used what we've called a social accountability framework, which requires our education providers to ensure that person-centred care for people of all types, and everyone in Australia is provided for our pharmacists and specifically around different cultures, people with different backgrounds and including those with disabilities. That's our core set of standards which is, in essence, a floor an education provider cannot fall below when they're applying for accreditation.

MS EASTMAN: You've set out the criterion in your statements and it refers to disability generally but not cognitive disability specifically. Is that right?

MS CLARK: That's correct.

MS EASTMAN: Now, there are 18 universities in Australia and New Zealand who have been accredited to provide courses in pharmacy, is that right?

MS CLARK: That's correct. 18 in Australia and two in New Zealand.

MS EASTMAN: So 20 altogether in Australia and New Zealand. I'll come back to you in a moment also on Proposition 1.

Mr Martin, can I turn to you? Let me just turn up your statement, which I've lost. You are the CEO of the Australian Association of Consultant Pharmacy. Now, what is the AACP and how is that different to the Pharmacy Council, and then I will come to Mr Simmonds about the board. I just want to be very clear about what your respective roles and functions are.

MR MARTIN: Sure. We have a singular focus on pharmacists interested in conducting medication reviews under the *Community Pharmacy Agreement*. A pharmacist would come to us for the credential that, when successfully completed, would allow them to seek funding under the community pharmacy process. We have a singular, I guess I put it that way, a much smaller role than APC. So the pharmacists --- it's an online program, pharmacists are free to enter and leave at their own will. The assessment is based on a number of elements, based on knowledge and conducting case studies, fictional case studies to respond to a competency framework assessment we've created.

MS EASTMAN: So these would be pharmacists such as Dr Angley who may undertake a review of medication that a particular person has been prescribed and is perhaps using over a period of time, and the review is to assess the efficacy of the medications, is that right?

MR MARTIN: Correct, yes. They look for information from a doctor from other - from the person themselves on how the medications are working, what other issues are arising, provide a report back to the referring GP for them to consider what to do next for the particular person involved.

MS EASTMAN: And at Public Hearing 6 the Royal Commission convened last year, the focus was on the use of psychotropic medication and the regulatory framework around the use of psychotropic medication. The Commissioners haven't issued a hearing report yet, but the Commissioners did hear evidence of often long term and extensive use of psychotropic medications to manage what was described as behaviours of concern or challenging behaviours and this often involved people with cognitive disability. So against that background, can you tell the Royal Commission to what extent does the accreditation process that you have responsibility for require anyone seeking the credentials or accreditation to have a very deep knowledge and understanding of cognitive disability?

MR MARTIN: Okay. The process means that the accredited pharmacist needs to be aware of medications, how they react for individuals in terms of long-term use. They also need to look at what's happening for the patient, how is the patient responding to the medication and why is it being given. Is there a need for it to be given? All that becomes part of the report back to the GP. In aged care facilities, which is probably the more common area for this to be looked at, they also work with the aged care staff in seeking out why the person has been prescribed this medicine. The doctor provides information as well, and that creates the report back, but the pharmacist is looking at the need for the medication, what behaviours were required for the medication to begin in the first place, are they still necessary.

The competency framework we use is designed to get the pharmacist to question why medicines are being given, and question the ongoing need for that medicine, should it continue? Is it appropriate? If you don't think it's appropriate what modifications should be undertaken or recommended should be undertaken for that person to get the most benefit from their medicine?

MS EASTMAN: Mr Simmonds, can I turn to you. You're Brett Simmonds and you're the Chair of the Pharmacy Board of Australia?

MR SIMMONDS: Yes, I am. Thank you.

MS EASTMAN: Can you tell the Royal Commission what the role of the Pharmacy Board is?

MR SIMMONDS: Certainly, thank you, counsel. The role of the Pharmacy Board is to register certified and competent pharmacists. We also develop registration standards, codes and guidelines in accordance with national law. We approve accreditation standards that are developed by Australian Pharmacy Council and we also approve education accredited programs of study. We oversee the assessment of overseas paid applicants for registration and we also make regulatory decisions about individual registered health practitioners. Now, that might be a concern of the suitability for registration or it could be the result of a notification or complaints, and we look at whether we need to take regulatory action around that particular practitioner.

I think that basically covers things, counsel. Thank you.

MS EASTMAN: According to the statistics published by the Board, as at December last year, there are 35,000 registered pharmacists in Australia? So I've taken that from your data.

MR SIMMONDS: Yes, that would be approximately correct, yes.

MS EASTMAN: And the majority of registered pharmacists are women.

MR SIMMONDS: Yes, they are. It's about, I think, about 55 per cent --- 35 per cent

at this stage.

MS EASTMAN: And I think Australians will be very familiar with pharmacists. They are part of everybody's life at different points in time, and it's likely that pharmacists in a range of areas are going to have interaction with people with disability, but also people with cognitive disability during the course of their practice and operating their businesses as pharmacists. Would you agree with that?

MR SIMMONDS: Yes, I would, counsel, yes.

MS EASTMAN: So there are going to be areas where particular pharmacists develop particular speciality or expertise, for example, in the home medication reviews areas. But for the everyday pharmacists, you'd agree, wouldn't you, that it's important for pharmacists to have a working knowledge of the care and treatment and delivery of health services for people with cognitive disability?

MR SIMMONDS: Yes, I do. I agree they would come across cases like this all the time in practice, yes.

MS EASTMAN: So I want to open up on Proposition 1, which is the competency framework and it has a number of elements to it.

Professor Abernethy, can I start with you. From a university perspective and your expectations of graduates completing pharmacy --- but I know you've also touched on speech pathology and psychology --- what is the expectation of a graduate from the University of Queensland with respect to competency and in that context do you support Proposition 1 in relation to the development of a competency framework?

PROFESSOR ABERNETHY: Thank you, counsel. Perhaps if I can answer the latter question first, which is we would certainly support the framework. There would be an expectation that graduates coming out of a program would have the skill set and the expertise, but most importantly, I guess the soft skills, the empathy, the understanding, the ability to see things from someone else's perspective that would allow them to function effectively in providing healthcare support to people with cognitive disability and a whole range of diverse conditions.

In relation to the proposition itself, I think in the framework there's very little in there that we would disagree with or find objection to. Perhaps the only comment that I could make would be in relation to 1.4, and I know it says guidance, but the issue of guidance around appropriate modes of teaching, I think we would be certainly accepting of that as long as it wasn't prescriptive. One of the things that I think is important in any accreditation framework is sufficient room for local innovation rather than necessarily prescription about teaching modes. So as long as it was guidance, I think all the other things around the expected outcomes, the frameworks --- of course the people who have consulted on this, all makes enormous sense from an educational point of view.

MS EASTMAN: Can I take up the idea of it not being prescriptive, and how does that sit with what the Royal Commission's heard about crowded curricula. And that where there is a crowded curricula, compromises have to be made and matters have to be dropped off. If there's not a prescription about teaching methods and the inclusion of cognitive disability, is there a risk that in pharmacy or speech pathology or psychology that the crowded curricula might be at the expense of examining with the students appropriate healthcare delivery for people with cognitive disability?

PROFESSOR ABERNETHY: I think that's a fair question. We'd always, of course, be assessed by APC and others in terms of how well we met the outcomes, rather than necessarily the specific means by which that was achieved. And so the pressure on curricula is very real. There's, of course, a whole lot of core competencies that are required and year on year almost a layering of additional expectations. So how you fit those in is an important challenge for an educational institution.

One option which on the surface seems attractive is that you manage to find space for a dedicated unit, say in this case I'm prescribing for people with cognitive disability. The reality is that's really difficult to do in amongst a whole spectrum of things that has to be satisfied in a program. Instead, what you would hope to do is embed throughout the curricula, rather than in an isolated unit in one year, plenty of case studies, plenty of examples, plenty of appearances from people with cognitive disabilities and their immediate family. That would enrich that experience for students on the way through.

So there are many ways to deal with a crowded curriculum, the least favoured one is just adding another course to an already heavily prescribed curricula. A much better way, both pedagogically and practically, is to embed those experiences throughout the course of study. It's more likely then that those experiences and the skills that are acquired that way will also then persevere into the post-registration experience of graduates.

MS EASTMAN: Ms Clark, can I turn to you. Do you have a view on Proposition 1 and any comment you would like to make about from the perspective of accrediting university courses, do you hear about the crowded curriculum?

MS CLARK: Yes, counsel, I do, and I think this is - we don't dismiss that as a reality. With regards to Proposition 1 and what our views would be is that we would have very similar views to that of Professor Abernethy, that the discussion around a competency framework and the development of a competency framework could definitely be an appropriate mechanism for increasing the invisibility of this population within our education programs and co-designing education with people with cognitive disability and their families and carers.

I think - but similarly to Professor Abernethy, with regards to the actual pedagogy and the delivery methods, we work on an outcomes-based framework, and so we are somewhat reluctant to prescribe particular ways of teaching and learning and what has been presented from the UQ example here demonstrates to us the level that we

would be looking for from accreditation perspective.

MS EASTMAN: Mr Simmonds, do you have any views on Proposition 1?

MR SIMMONDS: Yes, thank you, counsel. Look, the Pharmacy Board would be supportive of a proposal to develop a competency framework and the board would also be keen to be involved with the development of such a proposal as well. I think it should be noted that pharmacy, as a profession, has a National Competency Standards Framework for pharmacists in Australia, and that helps determine the competencies required for an individual to practice as a pharmacist. But alongside that, there are several other cross-professional frameworks that exist for particular practice areas, and I would see a proposal like this sitting in that space. For --- an example I could give you would be around the National Prescribing Service - Prescribing Competencies Framework. That's a cross-professional framework for all health professionals who prescribe medicines, and it gives the ability for professions to then use that when, for instance in the board situation, utilising, developing registration standards and guidance for the profession. And I think it also provides the opportunity for education providers and training organisations to be guided in what sort of competencies are required in certain areas of practice. So, yes, we would all be supportive of that proposal.

MS EASTMAN: Would the issues around competency inform such matters as whether a pharmacist meets professional standards or whether inappropriate involvement in prescribing could give rise to professional misconduct or unsatisfactory professional conduct? And I ask this because these issues come up, for example, not in the psychotropics area specifically, but this is a regular matter that no doubt you have to look at in relation to prescribing of anabolic steroids, schedule 8 drugs and a range of other medications.

MR SIMMONDS: Yes, thank you, counsel. So, yes, we recognise these sorts of standards and competencies when it comes to looking at an individual practitioner, a random notification about the standard of practice, around conduct or performance, and the Board would then look at what was available in terms of the standards by peers, particularly around competency standards in such documents as the National Competency Standards for Pharmacists, and also in prescribing competencies and associated documents. So we would utilise all of those available because they're available to all professionals to be able to utilise in terms of determining their standard of practice.

MS EASTMAN: Mr Martin, do you have any views or comments that you wish to make about Proposition 1?

MR MARTIN: I'm definitely supportive. The competency framework for pharmacists is what we base our program on. We create a map for accredited pharmacists based on that process. Having an overarching mapping toward professions that would then inform the competency framework for pharmacists would sound like a logical approach to me. As I said in my evidence briefly, we're

busily at the moment remapping the new standards, new competency framework, I'm sorry, to what we do, to make sure there are no gaps and nothing missing, and we're building down from that to create a whole list of evidence examples for pharmacists to actually assess themselves every year as they are requested to by the Pharmacy Board. So I think it's an excellent starting point.

MS EASTMAN: So if there was sort of broad agreement in principle about Proposition 1, who, or which body, or is it Government, who takes responsibility of starting to get a commitment around the development of a competency framework? Who bears that responsibility? I'll open that question to everybody.

MS CLARK: Counsel, if I might start, I think the example that Mr Simmonds has given on the MPS medicines-wise competencies shows that it is across professions, but I think that has been a really useful way of developing standards, but from the national board's perspective I might pass to Mr Simmonds on that.

MR SIMMONDS: Thank you, Bronwyn. Look, I agree with what you've said and that's why I raised it as an example. I think the National Medicines Prescribing Competency is a cross-professional standard of competencies and I think it worked out really well in terms of getting a number of experts around the table, and from a whole lot of different professions and accrediting bodies as well, and also education providers. And I think it's a responsibility of everyone coming together to produce a document that everyone can then utilise, and I think it's very important to involve everyone in that consultation.

Now, I also think if the competency framework was specifically about cognitive disability, then I think it's very important to involve people and organisations that support those groups in the conversation as well. But I think it could be done on a number of different layers and everyone brought together.

In terms of who would have overall responsibility, I think it's sometimes the Commonwealth that has that responsibility. But I think if there was a number of professions involved then it's something that we could do from possibly an AHPRA point of view as well.

MS EASTMAN: I think one of the issues that the Royal Commission's heard is somebody's got to go first, and so is it a matter of the professions waiting either until Government says "This is a good idea", or should the drive come from the professions themselves and Government then asked to respond? So what we might call the proverbial chicken and egg scenario. How do you overcome that? Who goes first?

MR SIMMONDS: Look, I'm happy to go first. I think it can be driven both ways, I think, depending on the funding model as well. But I think if there's one organisation that can bring people together and possibly drive this, it could be from a National Registration and Accreditation Scheme-wise way of doing that which contains all the national health professional boards and the accreditation authority.

So I think that's one area that could drive this. Another way would be from Government, but I think there's several ways that can be done. So if the boards were keen and got together with the accreditation authorities, I think that's a good step forward to try to start to get this discussion going and consultation.

MS EASTMAN: Professor Abernethy, where do the universities fit in? We've asked these similar questions to the medical deans. Do you have a view from the other health professions?

PROFESSOR ABERNETHY: Look, it's a discussion and a development we want to be engaged with. Of course that involves a number of collective groups at national level that bring the nurses and midwives together, that bring the allied health professions together and the like. My response, perhaps naive to your question would have been I would have thought something that the Commission hinted strongly as a responsibility for AHPRA, with broad consultation to the whole range of stakeholders, would be a good way of progressing this forward. Anything that's very discipline-specific is just going to lead us into challenges around some of these other propositions around a common language of discussion across health professionals, interprofessional education, interprofessional care and so I think the fundamental thing is that it should be cross-profession, and the other which is probably stating the absolute obvious is the wider the consultation, the more likely it is to be adopted in a sensible light.

MS EASTMAN: That probably is a helpful point to move to Proposition 5, which is the collaboration and multidisciplinary approach. We've heard from the speech pathologists this morning that interprofessional practice is a better expression than multidisciplinary approach. Proposition 5 looks at training and education for health professionals, which suggests it should address the importance and skills necessary to work collaboratively with families, support people, advocates, professionals from various health and social disciplines. So Professor Abernethy, do students taking pharmacy, psychology, or speech pathology have that opportunity in their undergraduate courses and education to take an interprofessional or interdisciplinary approach?

PROFESSOR ABERNETHY: Counsel, I'm delighted you have asked me that question because I can give you a more positive answer now than I might have been able to a few years ago. What we did in our faculty was, in amongst the crowded curricula that we've already referred to, found space in amongst roughly a dozen undergraduate health degrees, a common first year program - a common first year course that introduced all health professionals to the Australian health system and the role of different professions in that. And this was taught in a blended learning way where the groups were comprised of students from different degree programs.

We've set that up in year 1 and then that's reinforced throughout the full four years by various scaffolded learning experiences where you'd have more than two professions together to look at particular case studies.

So from an educational perspective, we think this is so important that it's become front and centre for us how to train people to have the requisite understanding of professions but also the skill set to listen, to negotiate, to be able to argue a point and accept a point based on evidence, so that what graduates working together can offer is a single integrated care plan rather than as many care plans as there are professions involved in the codes.

Now, at an educational perspective, we can control that part. Where it becomes messy for us is at the interface between interprofessional education and then students morphing into care environments that may not be interprofessional. So it's almost a generational change, we think, in order to bring about really functional teams in the health system. But educationally we think it's absolutely imperative.

MS EASTMAN: Mr Martin, can I ask you, it seems obvious that in terms of doing home medication reviews, which involve report back to GPs and other health practitioners, and in the area of prescribing with psychotropic medications, probably behaviour support specialists and also NDIS providers, what approach do you take to collaboration and a multidisciplinary approach in the work that you do?

MR MARTIN: As part of the assessment program there's an emphasis on collaboration with the other allied health professionals. What we find from real practice is that where the links are there between the doctors and the nurses and the other support staff, that's when the most benefit is obtained from the program. They work together, they know each other, there's more conversation, more collaboration. So the ability to link to those other professionals is a vital component. We try and promote that through the assessment program as the beginning point, we also then try to highlight that through research and information available to accredited pharmacists from our website, and also through our two conference programs. So it's an important aspect. We push it as hard as we can, when we can.

Having a single point of entry for the information would be more useful for a lot of people rather than trying to find it themselves. We try and collate and collect. But looking at what we do, it's probably all a bit mismatched, we'd like a more focused way of obtaining that information for our people. But the collaboration is a must have for the program to work well.

MS EASTMAN: Can I ask you, just in terms of what you do through the assessment and the collection of data, what tools do you use to evaluate whether or not you're achieving a requisite standard of collaboration and a multidisciplinary approach? How do you measure that?

MR MARTIN: That's probably a difficult question to answer, actually. I think it comes down to the outcomes themselves. If the patients are receiving the correct care, the collaboration is working to the patient's benefit, that's probably one fault with the entire program is that the outcomes are not really centrically collected at this stage. There's an --- intuitively it seems the programs work well but there's no central collection of data on outcomes and that's been a fault of the program for the

life of the program.

There have been various research projects over the years trying to assess where the outcomes are and where they work. We're involved with one at the moment but there's no large-scale program, and an outcomes collection is probably something that needs to be done, and done well, over the next few years.

MS EASTMAN: That might take me neatly to Proposition 11 which is whether consideration should be given to establishing a network of centres of excellence on cognitive disability as hubs for training and resources, and also strengthening the opportunities for health professionals to access training across particular networks. I asked you the question about how do you evaluate and collect data. You say that's a difficult question. Would it be fair to say that there isn't at present a central approach to collecting or sharing data of this kind?

MR MARTIN: That's correct, yes.

MS EASTMAN: I ask members of this panel to think about Proposition 11: from your perspective, would there be a support for establishing a network of centres of excellence with a particular focus on cognitive disability and would that assist in questions such as collection of data, evaluation and developing different resources to assist health professionals to work collaboratively?

MR MARTIN: Without a doubt. It sort of mimics what we do with the program. We look for subject matter experiments and go to them for support in what we do in constructing our program and quality improving our program, having access to a point, a central point of information where we know that the information is up to date and appropriate, and has been written and put together by people who understand intimately what's going on with these individuals, that would be an amazing benefit, promoting that then, access to that material to all accredited pharmacists. I would think most of them would leap at the opportunity and have access to that material. Speaking to a few pharmacists recently, they were all quite experienced accredited pharmacists but they have to say they would be a little bit uncertain in dealing with people with major intellectual disabilities because they're not familiar with them because they don't see them all that much. So having access to material from experts would be a major plus.

MS EASTMAN: Mr Simmonds, Ms Clark, from a regulator's perspective, how would centres of excellence fit with your particular and respective roles and responsibilities? And I invite you, if there's anything you want to add to Proposition 11 at all.

MS CLARK: If I start, Brett?

MR SIMMONDS: Certainly.

MS CLARK: I think there would be considerable value in such a centre. I note the

work that's been done by NSW Health for the Intellectual Disability and Mental Health Core Framework and the resources that are available there, which I was not aware of until the Commission - listening to previous panels. I think that that would help us with the work that we do right across the professions for our accreditation standards to have an ability for a central place for people to get further information to develop their programs and to assess against those. So I would be in favour of that.

MS EASTMAN: Mr Simmonds?

MR SIMMONDS: Yes, from the Board's point of view, I think the Board would be very in favour of that as well. I would think it would benefit education providers and health professionals to be able to access that sort of information. So I think it would be a value for the profession as a whole.

MS EASTMAN: And again, I'm going to ask you the hard question: who should be responsible for the establishment of funding centres of excellence? Does that come from the profession itself or do we look to Government again?

MR SIMMONDS: I think we'd probably look to Government for that, would be my estimation. But I would think the funding is a key issue, as you would be aware, and I think that would drive sort of changes available in that space.

CHAIR: Mr Simmonds, you surprise me.

MS EASTMAN: Professor Abernethy, from the university's perspective, not only teaching our future pharmacists but also research that universities undertake, what would be the perspective from the university sector --- and I know you can only speak for UQ --- to networks of centres of excellence. You have had some experience of a centre of excellence in Queensland.

PROFESSOR ABERNETHY: So you've pre-empted my first comment which is, 1a, as it reads, is silent on the issue of research, yet as you described it there was a heavy reliance on data and evaluation, and I think in the world we occupy, centres of excellence would generally have a strong research component, and if you're looking at best models for academic health science centres, there are three legs to the stool. There's the healthcare delivery element, there's the educational and future workforce element, and there's research and development of best practice element. So I think centres that do that would perhaps more holistically than was described there, would have great support from the university sector.

The only other point I'd make is it's probably worthwhile, as a preparatory step, actually doing a serious audit of all of the resources that already exist in different parts.

In wearing another hat on the Australian Council Deans of Health Science, within the last month we've had some excellent resources, free resources circulated from - developed at Monash for allied health and disability. And there are other

entities around, like the CRC autism, for instance, which has developed a set of resources. So I do think it would be worth, before necessarily starting what looks like a very good idea, to actually have a good audit of what's out there already. I think we'd all be surprised if we could have that assembled in a single place and have good access to it.

CHAIR: That might suggest that a fourth element to such a centre would be coordination of a range of institutions. It's interesting that work that is done in one State is not necessarily disseminated to another State in a way that allows the other State to take advantage immediately of that work.

PROFESSOR ABERNETHY: Agreed.

MS EASTMAN: Commissioner, I'm conscious of the time and thank you for the indulgence in going a little over time. We have, again, just touched on the surface of many important issues and Commissioners, you've got a large amount of material provided by our witnesses who are participating in the panel today, and also other material that the Commission has received in other hearings including a very detailed submission from the Pharmaceutical Society of Australia which is part of the evidence for PH6, so I will be quiet, I won't ask any further questions and the Commissioners may have some questions.

CHAIR: Commissioner Galbally, do you have any questions?

QUESTIONS BY THE COMMISSION

COMMISSIONER GALBALLY: Yes, thank you very much. This is a very important area, of course, and Ms McGowan really outlined that. I'm interested in the relationship and the training relationship with GPs especially, because a lot of the overprescribing or the inappropriate prescribing, you're dealing with trying to wind that back and negotiating, almost. And so that interdisciplinary, interprofessional relationship seems very important and, you know, I wondered where that had got to in a formal sense, the two areas coming together so it's not just left to persuasion. If there are prescriptions inappropriate, you know, these groups are at risk so I would love some commentary on that, thanks.

MR SIMMONDS: I'm happy to start off if I can be of help there, Commissioner. I think you will find that from the Board's point of view, we look to our code of conduct to provide the basis for the interprofessional interaction and the way practitioners are supposed to act and collaborate with other health professions and I think it's really, really important, both the Medical Board and the Pharmacy Board have codes of conduct and I think it's very important to raise awareness with practitioners about that because I absolutely agree with you, the collaboration between health professionals is the only way we're going to get better patient-centred care. And I absolutely think it's something that we need to work on and I think we

can do it as a board, I think we can raise the awareness of that and have discussions with the Medical Board as well around that space. I think it's about focusing attention and actually raising awareness as well in that area.

MS CLARK: Commissioner, from a perspective of accreditation standards, a significant change in the last few years around the expectation of interprofessional education has happened and with one of my other hats, I chair the Health Professions Accreditation Collaborative Forum, and we've just undertaken a review of all of the 15 professions' accreditation standards and we've identified that 13 of the 15 providers - professions require interprofessional and the other two were developing them as part of their accreditation standards. So with a better platform for our newly graduated professionals doing interprofessional education, such as Professor Abernethy has described, we expect the expectation will be that the relationships and the collaboration from a university perspective will flow into practice.

PROFESSOR ABERNETHY: Commissioner, could I just add one element which is kind of a research element to your question. You may or may not be aware the Medical Research Futures Fund has just quite recently put out a call for major research projects that are looking for safe use of medicines that deal with some of those questions around health services interfaces. So it may well be that some of that research will be valuable in informing the question that you posed to us.

COMMISSIONER GALBALLY: Thank you.

CHAIR: Commissioner Atkinson.

COMMISSIONER ATKINSON: Professor Abernethy, I'm particularly interested in the dental school within your faculty but that's not the subject of this particular panel. It's a later panel. Perhaps I might suggest we might put some questions in writing to you about that.

PROFESSOR ABERNETHY: Okay. I'd be happy to try and to answer those.

COMMISSIONER ATKINSON: It's particularly the Doctor of Clinical Dentistry and Special Needs Dentistry.

PROFESSOR ABERNETHY: Yes.

COMMISSIONER ATKINSON: Thank you.

COMMISSIONER BENNETT: I'd just like to, perhaps more connected to Grant Martin's material, expand upon Commissioner Galbally's question about what actually - what a pharmacist actually does now when they have concerns, other than a polite letter and maybe a phone call to the prescribing GP, and one of the - some of the material I've read is a scenario that I will put to you is that for a number of group homes there could be the same GP shared by a number of residents and then it's the same pharmacist that will assemble the medications into the blister packs. What

happens when they realise - a pharmacist sees a pattern, the nature of drugs, or an overprescription of drugs, or an interconnection of the drugs that are not the right mix, what do they actually do to prevent that happening? What support do they get? What is the complaint mechanism? How do they actually pursue that if the polite letter doesn't work?

MR MARTIN: That makes a difficult situation. To get a quick response, it's not a fast process to put a complaint through the system. It can take some time. Pharmacists have professional responsibility to act on what they're seeing so if there is a major concern they need to - or the encouragement is to actually consult more with the doctor and push the point that there is an issue here.

As to getting more support, they can refer to other colleagues, they can also refer to other people in the practice but the working with facility itself, discuss the issue with the doctor, looking for a meeting with the group is options for them within that facility. But a structured complaint is a difficult process and does take time for the process to work through the system. So it's not ideal for an immediate response.

It comes down, I think, really the pharmacist needs to step up and push if they don't believe what's going on is correct, or there's a major fault, they need to push back with the doctor and insist on a meeting with the doctor to resolve the situation, otherwise, it could go on for weeks or months before there's any resolution formally. And that's the hard part, I suppose. Many pharmacists are hesitant to argue the point too vigorously with the GP. But it comes down to professional responsibility and that's what they really need to do as part of their role as a health professional.

I know I've seen examples recently in the media where a pharmacist has backed down on a situation with an overdose medication in his role to the detriment of the patient, of course. That's what we try to encourage or we point out these situations and encourage people to stand their ground and talk through the clinical issues, the therapeutic issues and push it back with the doctor until they get a resolution. It's their responsibility as a health professional, in our view.

COMMISSIONER BENNETT: Is it something more needed other than just ideally if collaboration works and professional understanding and client focus, the individual, is there some other mechanism that's needed where that quick alert can say there is a pattern emerging, there is a problem here, and it's not being fixed fast enough to the benefit and the protection of the individual?

MR MARTIN: Having a rapid response from a third party umpire, for want of a better word, might be valuable. That would need to be someone highly qualified across a range of fields including the therapeutics involved. But being able to refer an issue quickly to someone like that with further consultation to the doctor with more support from that person might result in a much faster response to amendment for change to treatment patterns. It would be a difficult and I think expensive system to set up but in extreme circumstances could save lives.

CHAIR: Professor Abernethy, just as a matter of interest, why is the entry degree for pharmacy an honours degree?

PROFESSOR ABERNETHY: With the changes in the Australian quality framework a few years ago, four-year degree programs have honours built into them rather than as a post-graduate separate year.

CHAIR: So you can get a Bachelor of Pharmacy without honours but that won't be sufficient to gain you entry into the profession?

PROFESSOR ABERNETHY: Well, that may differ and my colleagues might be better positioned to answer that in respect to other universities. In our case, all we offer in the four-year entry degree is a Bachelor of Pharmacy with honours.

CHAIR: Thank you. I will ask Mr Costello, Ms McMillan, Ms Furness if they have any questions of the panel?

MR COSTELLO: No, thank you, Commissioner.

MS McMILLAN:. No, thank you.

MS FURNESS: No, thank you.

CHAIR: In that case, thank you very much for coming to the Commission and giving evidence today. We very much appreciate your assistance, including the statements that you have prepared and other information in writing. Thank you very much.

MR SIMMONDS: Thank you, Commissioner.

MS CLARK: Thank you, Commissioners.

THE WITNESSES WITHDREW

MS EASTMAN: Commissioners, could we adjourn now for the lunch break but slightly shorter than an hour and if we can return at 1.10?

CHAIR: Alright.

MS EASTMAN: Thank you.

CHAIR: We'll adjourn until 1.10 Sydney time, 12.10 Brisbane time.

ADJOURNED **[12.29 PM]**

RESUMED **[1.08 PM]**

CHAIR: Yes, Ms Eastman.

MS EASTMAN: Thank you, Commissioners. The next panel is a psychologist panel, and you will hear shortly from Rachel Phillips who is the CEO of the Psychology Board of Australia, Michael Carpenter from the Australian Psychological Accreditation Council and Dr Zena Burgess from the Australian Psychological Society, and this panel will focus on propositions 1, 3, 7 and 10, time permitting.

CHAIR: Ms Eastman, I might take the opportunity to explain to the panel where everybody is. Ms Eastman, who will ask you some questions, is in the Sydney hearing room together with Commissioner Atkinson, Commissioner Bennett and myself. Commissioner Galbally is joining the hearing from Melbourne.

DR ZENA BURGESS, PREVIOUSLY SWORN

MR MICHAEL CARPENTER, PREVIOUSLY AFFIRMED

MS RACHEL PHILLIPS, PREVIOUSLY AFFIRMED

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS EASTMAN: As at December 2020, there are almost 41,000 registered psychologists in Australia. 80 per cent of registered psychologists are women and many women were part-time. In terms of the area of psychology, the areas of practice endorsement, and Ms Phillips discusses this at paragraph 64 of her statement, are as follows: clinical neuropsychology, clinical psychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology, organisational psychology, and sport and exercise psychology. So the area of psychology and the work that psychologists do in Australia covers quite broad areas which are not just confined to the health profession but more broadly across many aspects of our lives.

To become a registered psychologist in Australia generally involves a six-year sequence of education and training. It typically is a four-year board-approved accredited sequence of study, followed by two years psychology board supervised practice program.

Members of our panel today all have great experience in the way in which psychologists undertake their professional duties and I want to start with Dr Zena Burgess. You are speaking on behalf of the Australian Psychological Society, the APS?

DR BURGESS: That's correct.

MS EASTMAN: And what's your role with the APS?

DR BURGESS: I'm the Chief Executive Officer.

MS EASTMAN: How many members are there in Australia?

DR BURGESS: We have 25,000 members of whom about 18,000 are fully registered psychologists, the others are psychologists in training and students.

MS EASTMAN: And your role for the APS, what does that involve?

DR BURGESS: I'm responsible for the staff at the office and for stakeholder engagement and for advocacy and assisting with policy development.

MS EASTMAN: And in terms of the areas of work, I've just listed a number of areas where there's the recognised practice endorsement areas. In your experience, can you tell the Royal Commission where do psychologists most frequently work?

DR BURGESS: A large proportion of psychologists work in private practice. They also work in schools. Some in the public sector and various psychologists working in corporate settings, either in HR, learning and development, and management consulting.

MS EASTMAN: And to the extent you can answer this question, and if you can't please let me know, with the number of psychologists who are either members of APS or more broadly, I think they have almost 41,000 registered psychologists, how many psychologists would have the responsibility for the care and treatment of people with cognitive disability on a day-to-day basis?

DR BURGESS: I couldn't answer that statistically.

MS EASTMAN: Would it be the case that you would expect that psychologists would, at some stage during their professional career, have the responsibility for the care and treatment of people with cognitive disability?

DR BURGESS: A number of psychologists work with the NDIS and clinical psychologists and forensic - sorry, neurological psychologists. Some counselling psychologists certainly work with families and people with forms of disability, cognitive disability, and some psychologists who work in schools. But actual

numbers I couldn't give you.

MS EASTMAN: And do you know if there is any source of data that identifies the number of psychologists who may have interaction with people with cognitive disability? Do you know if that data exists?

DR BURGESS: No, I don't.

MS EASTMAN: Rachel Phillips, can I turn to you. You are the CEO of the Psychology Board and you have also provided a statement to the Royal Commission. Can you tell us what is the role and responsibility of the Psychology Board?

MS PHILLIPS: Thank you. I'm the Chair of the Psychology Board of Australia, which is a ministerial appointment. The Board, within the National Scheme, the National Regulation and Accreditation Scheme, is responsible for ensuring that there are suitably qualified psychologists trained, and there's a sustainable supply of that workforce to meet the needs of the Australian community.

So there's five broad objectives underpinning the National Law that's outlined in my submission.

In terms of the last two objectives around access and sustainable workforce supply, that is probably something that is the focus of this Commission more broadly.

MS EASTMAN: So the Board has the responsibility for registering psychologists and provisional psychologists, is that right?

MS PHILLIPS: Correct.

MS EASTMAN: Developing standards, codes and guidelines for the psychology profession?

MS PHILLIPS: Correct.

MS EASTMAN: You also deal with notifications, complaints, investigations and the disciplinary side of regulating psychologists, is that right?

MS PHILLIPS: Correct.

MS EASTMAN: You also oversee the assessment of overseas-trained psychologists who wish to practice in Australia?

MS PHILLIPS: Yes.

MS EASTMAN: And you approve accreditation standards and accredited courses of study, is that right?

MS PHILLIPS: Yes, that's correct.

MS EASTMAN: Part of that work will take us to Mr Carpenter, who is the CEO of the Australian Psychological Accreditation Council, APAC.

Mr Carpenter, is it right that APAC is an independent quality and safeguards organisation appointed by the Psychology Board of Australia as the higher education accreditation authority?

I might need you off the mute, if that's okay.

MR CARPENTER: My apologies. That's correct.

MS EASTMAN: APAC was established in 2005 to set national standards of education and training of psychologists and to accredit programs of study, is that right?

MR CARPENTER: That is right, yes.

MS EASTMAN: Now, in your statement which you've provided to the Royal Commission, you have provided us with a graph that sets out or a little image that sets out the way in which the accreditation standards operate and it looks a little complex. I'm going to ask that that come up on the screen and ask you just to explain the process of accreditation.

Commissioners, if the Commissioners are using their hearing folder prepared for today's hearing, you will find behind tab 21 ---

CHAIR: Thank you.

MS EASTMAN: --- Mr Carpenter's statement, and if you turn four pages in, you will see that there is a copy of the graph that's just been - or the image just been put up on the screen.

Mr Carpenter, can you walk us through what looks, on paper, to be a very complex assessment and accreditation system with lots of different steps? How does this work in practice?

MR CARPENTER: Sure. So within the whole process, as you with see, there are multiple steps but there are four main parts to it. There is the initial assessment of the program and of the 650 to 700 or so programs that are accredited by APAC we will thoroughly review those at least once every five years. So this diagram you've got shared on the screen really refers to that process.

So there are really two parts to the assessment that we undertake and the first is the left-hand column as part of which the education provider makes a significant written submission to us, demonstrating how that program of psychology meets the agreed

national standards. That's reviewed by a panel of appointed assessors who are experts in their field and trained to undertake the assessment. That's then supplemented by, as you see in the second column, the so-called site visit where our team of assessors will normally visit the premises of the higher education providers and several days meeting stakeholders in the program --- staff, students, supervisors --- testing what the education provider has provided in the written submission, and assuring themselves that either the standards have been met or identifying whether there are shortfalls against those standards.

Then, post that site visit, which is the last formal part of the assessment process, that team will provide a detailed report on how the program or programs meet the standards, again identifying where there may be any shortfalls, and then that's communicated - sorry, the decision is then communicated to APAC's board who make a formal decision on whether that program is accredited, and if so, whether any conditions apply to that program which are essentially shortfalls that have to be made good. Then our decision is reported to the Psychology Board of Australia who have their own process for then approving that decision as a qualification that will lead to registration.

Now, the final column is really the work that takes place between those five-yearly visits. So we don't assess a program and leave it for five years and come back. There's ongoing engagement with that education provider and their programs including an annual report provided by the education provider which advises us of any changes that impact on the program, any developments, and gives us early warning of whether there may be issues that we've got to dig into. So this is a continuous cycle that applies to all the programs we've accredited.

Obviously very happy to go into more detail, but that's how it works at a high level.

MS EASTMAN: Mr Carpenter, I might just get your sound quality checked, so bear with us, but I might turn to you, Ms Phillips.

In terms of accreditation standards for psychology, the current accreditation standards came into effect on 1 January 2019, is that right?

MS PHILLIPS: Correct.

MS EASTMAN: And in terms of the accreditation standards, can you tell the Royal Commission the extent to which those standards makes specific reference to the care and treatment of people with cognitive disability?

MS PHILLIPS: So, the standards that do align with the general registration competencies for psychologists in Australia that are across eight competency domains, and so any of the standards in terms of application of assessments, psychological interventions, working with people across diverse groups, would be inclusive of people with a cognitive disability. This is - so the standards are aligned in terms of foundational knowledge, pre-competency, and then professional

knowledge. So it's a pre-competency professional knowledge and then the professional knowledge components. So if you think of it as a sequential learning of those general registration competencies from year 1 through to year 6.

MS EASTMAN: Now, I want to move to the propositions and I think all of you have got a copy of the proposition documents.

Dr Burgess, can I start with you in relation to Proposition 1 which is the competency framework, and I think you've expressed some views about a competency framework in your statement. Can I ask you, does the APS support a competency framework?

DR BURGESS: The APS came to see a competency framework for better interventions and better care and treatment of people with cognitive disabilities. We're keen to see the importance of --- we see the importance of including the development and application of a competency framework that addresses the clauses 1.1 and 1.2. And we see the APS and other peak bodies as having a role and influencing the professions in having best practice in this area.

MS EASTMAN: How would that be done?

DR BURGESS: We work collaboratively with other organisations and develop a comprehensive framework, and we also work actively to develop professional development programs for people who are fully trained or on the way through training for them to develop skills in particular areas that reflect the emerging needs of the profession.

MS EASTMAN: In terms of a competency framework, what is your expectation about the application of a competency framework to the undergraduate university education, and then as I understand it, that there's a requirement to complete a masters of psychology if one wants to follow the pathway to become a registered psychologist? Do you see room for a competency framework at that early entry level stage?

DR BURGESS: As Rachel described it, the theoretical knowledge would be included in what is already taught in the sequential programs. The opportunity comes from having placements for students where they can work actively under supervision with members of the community who have cognitive disability, so they have exposure to the work and experienced professionals to coach them to ensure they work really well. So that then builds a workforce that's used to working with the client population and doing so effectively.

MS EASTMAN: I want to come and ask you specifically about Proposition 7 which is the supervised clinical placements in a moment, but Ms Phillips, can I ask you about the Board's view on a competency framework? What's the board's position?

MS PHILLIPS: Thank you. We are absolutely in support of an interprofessional approach to competency development for healthcare practitioners in regards to

cognitive disability and how better to support people. We agree with Proposition 1.4 where it actually talks about a tiered approach, and the way that I like to think about it is that it's thinking about what should every health practitioner know about working with people? What do you need to know as part of your profession? And so that would be something that would become part of your professional training. And then what do you need to know, based on your location of work? So this could be part of the NDIS that already has a capability framework or other sectors where health professionals work.

I think the other point the Board would like to make is that we really need to think about how we teach health practitioners to work with each other in delivering services to people with cognitive disability because they actually, the most complex of cases that might come into our health services are the ones that will fall through the cracks and that's usually a system issue, it's not a patient or a client issue. So adopting an interprofessional approach that actually assists health practitioners to reflect on how they deliver care, and the process of engagement, of listening to people, I think is fundamental to any training approach.

MS EASTMAN: How can that best be done in your view?

MS PHILLIPS: Well, I think it's actually having a commitment to a multidisciplinary or a multi-profession approach that is actually co-designed with people who have lived experience of disability and also their carers.

MS EASTMAN: How do you do that?

MS PHILLIPS: Part of that is actually sitting down and talking about when things have gone wrong or when things have actually gone right, and what are the key principles --- the polar experiences of people, and how can we actually instill this into what I like to call the art of caring.

So we assume that health professionals are competent, but actually what people want is they want to know they care about them, and so that they can then trust their loved ones. If it's a carer or that someone who isn't able to communicate their needs, that the health practitioner will actually work as hard as possible to understand, and that's a process. That is something that I think from a communication point of view you can only do through scenario-based learning, working with people with lived experience to actually change your approach in, I guess, the environment that you work.

MS EASTMAN: Mr Carpenter, just taking up Ms Phillips' description of ways in which questions around care and developing that sense of care in our practitioners, how does that fit into the work that you do when you look at courses for the purpose of accreditation? Do you look at what some might call the soft skills?

MR CARPENTER: Absolutely, and I'll try to speak up a little bit if there are sound quality issues.

So the accreditation standards for psychology programs that you referred to a little earlier, that were launched two years ago, do have a specific reference to interprofessional learning and collaboration. So there is a requirement now on providers of programs seeking accreditation from APAC to include an element of interprofessional learning, and so that obviously looks different at the undergraduate level to the postgraduate level. But it's something we assess, it's something we expect to see, and I think something we're seeing education providers better engage with.

So I guess a good example of what you might see at the postgraduate level is an education provider actually offering opportunities to students in psychology to work as part of a case team with students from other health disciplines, working with patients in clinical settings. So that is something that's starting to happen and it's absolutely something we require to happen as part of a psychology education;

MS EASTMAN: Dr Burgess, from your perspective, do you see, from the views of your members and understanding the experience of your members, whether there is opportunities to develop this concept of care and instilling in new graduates care as a mode of engaging with their clients?

DR BURGESS: I think certainly people who go into the profession start from a willingness and a wanting-ness to care for others and to be carers and professional supports and advisers and offer interventions. That's the start of where they start. The gap is, as I started to say earlier, in providing opportunities for placement in settings where they can work in as part of multidisciplinary teams, they can work alongside other psychologists and learn to be skilled professionals in this area. That is a difficulty and one of the challenges that gets in the way of people completing their training as easily as they could.

MS EASTMAN: So that sort of takes us to Proposition 7, which is dealing with the supervised clinical placement issues. Why is that such a difficulty in the field of psychology? Is there something that's happened recently? Is it something to do with changes to the rollout of the NDIS? What's the reason?

DR BURGESS: I don't think it's just changes with the NDIS, but I think that hasn't made it easier. I think it's very hard to find enough places of employment that allow the scope for practitioners to have the time to supervise others and the willingness to supervise others and Rachel will have views about this as well.

There seems to have been something that's lost in the culture of professionals to supervise others and take on the responsibility of that. So it's partly culture, partly time, partly it's structure of workplaces, but it's one of the big things that if it could be addressed it would make a huge difference in this area.

MS EASTMAN: What particular clinical placements or clinical settings do you think psychologists in their training phase need to have? Where do we look to? Is it

a hospital setting? Is it in private practice? Is it in a school setting?

DR BURGESS: It would be across the board. You could provide opportunities in any of those settings and it would benefit the population of people we're talking about now.

MS EASTMAN: Who has the responsibility to either offer or fund clinical placements?

DR BURGESS: I can't say who would have the responsibility, but it would be fabulous - at the moment these positions are not really funded so there has to be funding found for them. It would be the employing organisation would need to find the funding or the students, well, I don't want to volunteer the students to fund their own placements.

MS EASTMAN: No. Ms Phillips, have you got a view on Proposition 7 and the supervised clinical placements? What's the current concerns of the Board?

MS PHILLIPS: Thank you, counsel. What we've observed, probably, other the last 10 to 15 years, so I think it is longer than the commencement of the NDIS, is that while psychologists in their pre-entry training have more than sufficient exposure to individual differences, so people with disability across the life course, they don't have as great an opportunity anymore to actually consolidate that learning through placements or work integrated employment.

Placement capacity seems to be influenced by a couple of drivers, so one of the ones that the Board has looked into in depth is whether there's sufficient numbers of supervisors who are suitably trained to supervise provisional psychologists and the Board has a process of which any psychologist with the required number of years' training does a course, so that they can safely supervise provisional psychologists. And current numbers is that we actually have a 1:2 ratio of supervisors to provisional psychologists, so that's actually not a problem, we have enough supervisors in Australia.

Where we're actually struggling is around the capacity to provide supervision to psychologists working in - being immersed in the disability sector. So traditionally, before the NDIS, psychologists would work in the State Government disability services in, say, a behaviour support role, and do their training or placements there. Now that the NDIS model has changed to a fee-for-service model, those supervision opportunities aren't readily available because any senior psychologist is now a provider and so the governance arrangements are to actually take on students would be seen as an add-on or potentially a lost income opportunity. And I say this generally because I do know that there are psychologists who are incredibly invested in training the future workforce, but what we've seen and what we hear anecdotally, and I think that's what Zena's referring to, is there's been a gap of actual day immersion. So where placements now are for provisional psychologists to actually hone their skills with people with disability are at the pointy end. So they're in the

health sector, they're in forensic mental health, they're in correctional services. There's always been a really strong foothold in education, but you actually probably even need it earlier than that in the childcare setting, but also the early intervention of the NDIS oversees.

So what we're finding is psychologists are getting good assessment skills, but in terms of actually supporting functional behaviour assessments and positive behaviour support plans, the Board's quite concerned about the future workforce supply and availability of those skills that are actually really fundamentally required to reduce the need for restrictive practices, to reduce offending and people prematurely or entering the criminal justice system, but also not being able to get their needs met when they enter healthcare.

MS EASTMAN: The Royal Commission heard at Public Hearing 6, which looked at the question of psychotropic medication, the Commissioners heard a lot about the area of behaviour support practitioners, and many practitioners seem to come from backgrounds of psychology or experience as psychologists or counsellors. And this is an area which the Royal Commissioners heard is now also regulated by the Quality and Safeguards Commission. What has that meant in terms of the work that the Board has done in working with a new regulator such as the Quality and Safeguards Commission? Is that something that the Board has had to address?

MS PHILLIPS: So we regulate individual practitioners and we oversee the development of accreditation standards. So while we have heard from the Commissioner into safety and quality --- in disability, the working relationship is still in relation to individual practitioners. Having said that, I do think that the implementation of the Senior Practitioner, who actually oversees the use of restrictive practices but also approves specialist behaviour support, is incredibly important in terms of instilling good governance within the scheme.

I do think that there is an opportunity to look at how psychologists can support the training of other professions when it comes to functional behavioural analysis. That's our bread and butter in terms of understanding someone's behaviour, what drives them, what reinforces it. And so it does concern the Board that probably students aren't getting those opportunities to really consolidate those skills, and we know that if you do a clinical placement in - or a placement to start with, in an area of employment, you're more likely to work there.

CHAIR: Ms Phillips, can I ask you how what you've just said is consistent with your answers to question 9 in your statement, which appears, at least in the printed version, on page 12 of 13. In particular, paragraph 74 says that:

> *The [organisation] considers that the general psychology competencies and the AoPE [that is area of practice endorsement] competencies are sufficient to meet the needs of clients with intellectually or - I assume that's meant to be intellectual or cognitive disability. Our experience suggests that it would be extremely unlikely that a 'case for action' could be made to the Ministerial*

Council to agree to a new [program] relating to the care and treatment of people with intellectual or cognitive disability. Introducing a new AoPE may not be in the best interests of clients with cognitive or intellectual disabilities ....

The argument, as I understand that you've put in your statement, the eight areas that you identify as core competencies, equip all psychology graduates to provide care and treatment to the extent necessary to people with cognitive disability. That appears in paragraph 67 where you say:

.... all psychologists are expected to be able to practice safely and professionally with clients who present with cognitive and intellectual disabilities.

Isn't what you've just been telling us that there are gaps in the educational program and we can't assume that all psychologists have the skills that are necessary to act safely and professionally with clients who present with cognitive and intellectual disabilities?

MS PHILLIPS: Thank you for your clarification, Commissioner. I probably would proffer a different interpretation of what I've said in relation to my submission. I think that the difference between minimum threshold, as demonstrated by competency and someone wanting to go and work in the disability sector are two very different things. So all accredited programs and all supervisors must confirm that someone is competent and eligible for general registration at the completion of their training and that will include exposure to clients with varying degrees of cognitive disability.

The placement opportunities that exist probably are not as varied as what they have been in the past, and more focused on other government sectors than probably the exposure to the disability sector.

So psychologists work in every sector of employment in Australia. We're quite diverse in terms of our skill set, and so what I'm proffering is that we have the necessary theory, knowledge and skill set but there isn't the, I guess, the linkage opportunities that you get from placements in the sector to then encourage more psychologists to work in the disability sector.

CHAIR: Isn't the whole point of an area of practice endorsement that it is a voluntary means by which a psychologist can get an endorsement --- in other words a tick that everybody can see --- that that person has got special skills in a particular area, whether it be forensic psychology or organisational psychology, which are two of these areas that you have identified? Why doesn't exactly the same reasoning not apply to psychologists who wish to work with people who have cognitive and intellectual disability? After all, it's a voluntary program and it signifies that someone has done extra work and should be recognised as such, which is a very common thing in the profession.

MS PHILLIPS: So I think there is a difference, Commissioner, between a vocational area of interest compared to an area of practice endorsement as it's understood under the National Law. The area of practice endorsement, is a recognition of advanced qualification and they're deliberately focused on areas of practice, not to particular client groups. So, for example, if you undertook a period of training for forensic psychology, you could work with client groups across the forensic sector, so whether that's in mental health, Corrections, Family Court. So it's deliberately broad. So when you, for example, look at disability, this would also encompass clinical neuropsychology, or the competency domain that we tend to focus on that would be related to client groups would be psychological assessment, and then also the psychological interventions are quite broad in terms of teaching psychologists around test selection, test administration, and then formulating bespoke, tailored treatments to that client in front of them.

So we feel that the competencies that have been developed aren't necessarily broad enough to encompass cognitive disability, but we feel there's been a change in market forces that have influenced interest of psychologists to actually work in the disability area.

CHAIR: Yes, thank you.

COMMISSIONER GALBALLY: Could I ask a question at this point? I'm just - it's the same with numbers of professional areas, that in the change to disability, which is people moving out into the community no longer, you know, like to some degree, no longer living where they're conveniently reached, you know, they're out doing all sorts of things, people with cognitive disability, which is really great, is that part of what makes it harder? In the old days you could go into State facilities and there they all were and now they're out in the world and it's harder to ---

MS PHILLIPS: To access them? I think that is a wonderful clarifying question, Commissioner.

Look, I think that the business model is a huge driver in terms of what psychologists choose to do in terms of their work. So there has been a change in workforce demographics over the last 20 years that has undoubtedly been driven by changes in funding. So where before the majority of psychologists worked in government sectors or in human resource environments or large consulting firms, the majority now work in private practice, either small or sole providers. So there's a business model. And Medicare, I think, has influenced this really strong workforce growth that we're seeing in people wanting to become psychologists, but it's also the demand is so great, so they can pick and choose.

So I think that that is a driver. I don't think there has been a change in terms of wanting to assist and to help. I do think that there is a link between if you have a placement in a particular area, you will be more likely to go and work in that area, and so Zena's earlier point around placements is absolutely a driving factor, I think,

to some of the challenges that have been reported.

MS EASTMAN: Dr Burgess, can I come back to you just to finish Proposition 7. What reforms do you think need to occur to improve supervised clinical placements being available for people training as psychologists?

DR BURGESS: Commissioner, could you ask me that question again? A couple of things popped into my mind, I want to know where to start appropriately.

MS EASTMAN: I'm inviting to you to say what you would like to tell the Commissioners about what reforms, what needs to be done to secure supervised clinical placements for trainee psychologists.

DR BURGESS: I think that there needs to be incentives for people to offer the placements. Incentives for supervisors to supervise, both in the private sector and in the public sector, and as Rachel said, you could actually make it a pretty well mandatory rotation to have exposure to working in this area of disability. And once people have a first exposure, whether it's doctors or psychologists, they will stay in the setting. They get imprinted, they get attached to it. So it's getting that first exposure right and making sure it's a quality experience for them.

Helping people to reflect on their experience and to work with the carers and work in the settings with people with cognitive disability just - it's an exposure issue.

The other point I wanted to make is about what Rachel was saying about it being a business model. If a psychologist, whether they're a trainee or a supervisor, is paid a certain amount of money for doing one kind of work and a lesser amount of money for doing another, as a small business person, they will do the work that pays them the greatest amount. So there are times when the disability sector doesn't get selected because it isn't paying the rates that people can get elsewhere for other work. So that's part of it as well.

CHAIR: Is psychology a business or a profession?

DR BURGESS: Most psychologists are small business people working in private practice, and yes, it is a profession, but just like doctors and GPs and other doctors are in a vocation, they are also business people. As are lawyers.

CHAIR: What's your definition of a profession?

DR BURGESS: This is a tricky philosophical question. For me, it's about people who have a commitment to working in a particular kind of area, to do it to the best of their ability because they believe it's for the benefit of the community.

MS EASTMAN: Can I, in the time that's available, turn now to ongoing education and professional development and this touches on both Proposition 3 and Proposition 10, and Dr Burgess, you've provided the Royal Commission with a list of resources

and training material in appendix A and appendix B to your statement. And as I understand it, there is a mandatory ongoing professional development obligation that attaches to any psychologist who wishes to renew her registration year on and year out. Is that right?

DR BURGESS: That's correct.

MS EASTMAN: And, Ms Phillips, does the Board have any role in setting out what the ongoing CPD obligations are if somebody wants to maintain their registration?

MS PHILLIPS: Yes. So this points to the recency of practice requirements under the national law. So 30 hours are required each year to be undertaken by a psychologist so that they annually declare that they've completed those hours. Ten of those hours must be on peer supervision, so reflections on their own practice, and the remaining 20 are strongly recommended to be active forms of supervision where they have the opportunity to develop a learning plan that identifies where there might be gaps in their knowledge or whether they need to refresh their skills, and they align their professional development activities to that learning plan.

MS EASTMAN: So of those 30 hours, there's no mandatory requirement to spend one or more of the hours looking at cognitive disability as an area for ongoing training and development, is that right?

MS PHILLIPS: Correct. It is required to be in relation to their competencies that they've achieved at time of registration, both general and/or area of practice endorsement, and also their recency of practice. So an example might be, in the area, let's say, a psychologist changed work roles and moved into an area where they're regularly completing assessments for learning disabilities. They've identified that they haven't administered one of our core psychometric tests for some time and so it would be reasonable to expect that they would undertake a focused effort to refresh their skills and to be able to demonstrate that if required through an audit process.

MS EASTMAN: Are there any areas at all that you require people to specifically focus on to complete the 30 hours? Is there any prescribed areas at all?

MS PHILLIPS: No, it just has to relate to psychological practice. So it needs to be defensible in terms of how it relates to them as a regulated health profession and as a psychologist. If they have an area of practice endorsement, 15 hours must be - so half of that must be dedicated to that area of practice endorsement.

MS EASTMAN: Mr Carpenter, sorry, you've been silent while I've covered Proposition 7. In terms of your experience from the accreditation side, do you have any views on the ongoing training for psychologists in practice? Is that something that you turn your mind to in looking at the accreditation of courses?

MR CARPENTER: It's a little bit beyond the scope of what we do. What we do is limited, really, to looking at the training of staff within the higher education

providers delivering the programs. So there is some requirement within the standards for the higher education to demonstrate they're supporting continuing professional development. But there are no specific requirements in terms of what that looks like. Very much as Rachel's described.

MS EASTMAN: Dr Burgess, is it the case that if a person specialises in sports psychology for rugby league players, that the 30 hours of ongoing training and development could all be about psychology in rugby league? Is that possible, and nothing else?

DR BURGESS: In terms of the learning plan for professional development that we provide to our members, it covers three areas. It covers theoretical knowledge relevant to your work, practical knowledge relevant to your work and ethical considerations relevant to your work. So, yes, it could be about rugby but it would need to cover those three areas, and part of your supervision work with your active learning work would be to look at how that applies to other settings and other parts of work. So learning in one place, how it could be applied in others.

MS EASTMAN: Is there any incentive for psychologists who have a particular field of practice to step outside that field of practice and increase their general knowledge in psychology? So, for example, take the example I've given you of the sports psychologist specialising in rugby, is there any incentive to step outside that particular area and look at other areas of psychological practice?

DR BURGESS: I can only tell you what I've seen over 30 years of psychologists and their behaviour, and that's that they are intellectually curious and do. There is a great thirst of learning in the profession, and they are always looking for ideas from other parts of psychology that they can use to apply to their own practice. So there is no compulsion but there is a professional set of behaviours that seem to lead to that.

MS EASTMAN: While 30 hours of CPD sounds very important, would it be the case that as a psychologist becomes more and more specialised in her or his particular areas, that the opportunity to come back and to review, to update, and to develop an expertise in working with people with cognitive disability becomes more and more limited, the more and more specialised a person becomes?

DR BURGESS: I think psychology is such a broad area, there are always things to learn. You may become quite specialised in one small area, but there are other areas one always needs to learn about. So I think Rachel perhaps would comment on that but I would say that learning is an ongoing process for most psychologists.

MS EASTMAN: Ms Phillips, I suppose I've asked this question because, listening to your evidence this afternoon, if we don't capture the psychologists at the entry level on cognitive disability, once they take a clinical placement and that might be the area in which they remain for their profession, they might not ever have the opportunity to work with or to develop the skills to care for people with cognitive disability. Is that right?

MS PHILLIPS: So, would it be possible for me to just very quickly outline a piece of reform that the Board is undertaking in relation to part of your question?

MS EASTMAN: Yes, please do.

MS PHILLIPS: Thank you, Counsel.

All psychologists in Australia are on the General Register, so they are actually generally registered before they even consider completing a training in area of practice endorsement. So that means, at time of entry into the profession, they are fit for practice and competent to work in a diverse set of roles. If they choose to continue on to complete an area of practice endorsement, it does stand to reason that they will want to work in that area. But that does not remove the requirement for them to work within their individual competence, which is a combination of their training, their recency of practice, and their continuing professional development.

So I think that it's a little bit - well, we've made the link strongly about clinical placements. I think what we've also heard from multiple stakeholders is that there's a requirement to simplify and strengthen the registration categories for psychologists in Australia. So the Board has been undertaking some reform to actually make it easier for someone to become a psychologist, but also to make it easier for the community to understand what type of services they need and want and how to access them.

And one of those is actually just to really clarify the general registration competencies, which I think is where the most benefit is going to be for people with cognitive disability.

MS EASTMAN: Thank you for that clarification.

Commissioners, I have no further questions.

The Commissioners may have some questions, though, of the panellists.

CHAIR: Yes, thank you. Again, I'll ask Commissioner Galbally, have you any questions?

COMMISSIONER GALBALLY: No further questions, thank you.

CHAIR: Thank you. Commissioner Atkinson.

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner Bennett? Thank you.

I will ask the counsel who are appearing today whether anyone has questions of this

panel?

MR COSTELLO: No, thank you, Commissioner.

MS McMILLAN: No thank you, Chair.

MS FURNESS: No, thank you, Commissioner.

CHAIR: In that case, thank you, Mr Carpenter, Ms Phillips, Dr Burgess, for coming to give evidence today and assisting us both with the statements that you have prepared and your oral evidence today. We appreciate your assistance. Thank you very much.

MS PHILLIPS: Thank you for the opportunity.

THE WITNESSES WITHDREW

CHAIR: Do we take a short break now?

MS EASTMAN: The next panel is the dental panel and so we need a short adjournment of a minute or so to reconstitute the panels.

CHAIR: Right. We'll take a break. It's now just after 2. We'll take a break until 2.05 Sydney time, 1.05 Brisbane time.

MS EASTMAN: Thank you.

ADJOURNED **[1.59 PM]**

RESUMED **[2.04 PM]**

CHAIR: Yes, Ms Eastman --- oh, I'm terribly sorry. Yes.

MS WRIGHT: Commissioners, the Royal Commission will hear evidence from a dental panel consisting of Professor Robert Love, the Chair of the Australasian Council of Dental Schools, Dr Mark Hutton, President of the Australian Dental Association, Ms Narelle Mills of the Australian Dental Council, and Professor Hien Chi Ngo, the Dean of University of Western Australia Dental School.

The panel will focus on Propositions 1, 2, 6, 8 and 11. There are six registered professions under the National Registration and Accreditation Scheme. Our focus is on dentists who are the primary providers of dental services to the community. I won't list the other dental professions but they all form part of the dental team led by

a dentist.

At December 2020, there were 24,994 registered dental practitioners in Australia of which 18,626 were dentists. To become a registered dentist generally involves four years of graduate study or up to five years of undergraduate study and specialising involves further postgraduate study and that will be the subject of evidence shortly.

In Public Hearing 4, just briefly, the Commission heard evidence that dental problems and gum disease are common among people with intellectual disability, and of the significant risks to health they present including feeding issues, nutritional deficiencies and increased risk for respiratory and other diseases.

That evidence came primarily from Professor Julian Trollor, official visitors to group homes, carers of people with intellectual disability and specialist dentist Dr Richard Zylan and Mr Nathan Despott of Inclusion Melbourne.

Before calling upon the panel we wish to remind the Commissioners of some evidence from Ms Sabrina Monaghan during Public Hearing 4. Her son has a cognitive disability and complex health needs, and she spoke about issues and poor experiences accessing dental services at a community dental clinic for him in February at Public Hearing 4. So we will play two short one-minute extracts now.

[VIDEO RECORDING PLAYED]

MS EASTMAN: --- good healthcare is person-centred and individualised.

MS MONAGHAN: That's correct.

MS EASTMAN: And treating AAL first and foremost as a person and individual who understands and comprehends what's happening is important.

MS MONAGHAN: That's correct.

MS EASTMAN: Is that the number one starting point?

MS MONAGHAN: Of course it is, it has to be. You can listen to the patient's advocate and you can listen to them if they're able to communicate their needs, you know, spending time observing behaviours is often a clue of what that person is feeling and, you know, if they're fidgeting around or, you know, starting to stim a lot, that's obviously a sign they're becoming dysregulated, so plenty of time for a consultation to occur and just give that person some breathing space. Because quite often transition is a huge issue for a lot of people with autism, whether it's, you know, from school to home, but it could also be, you know, quite micro sort of managed within the environment, someone getting up and leaving, an object being moved on a table because they like things where they seem to think they like things,

so all those little nuances can tick them off, and little things are big things to them.

[VIDEO RECORDING ENDED]

[VIDEO RECORDING PLAYED]

MS EASTMAN: And you think that medical, dental and nursing staff are probably given very little education or training regarding managing people with disability, let alone specific training in autism?

MS MONAGHAN: Correct.

MS EASTMAN: And so one of your suggestions is that there needs to be some training, but not just the technical know-how but also improvement in the attitude and the mindset of clinicians, is that right?

MS MONAGHAN: That's right, yeah. I think some, you know, hands-on practical experience, whether working in, you know, a residential care setting or a special needs school, I think that would be really warranted and I think the social model of disability care needs to be imprinted on medical training as well so as they're not looking at it from a medical model, just to assume that, you know, they can be cured or, you know, that sort of thinking.

[VIDEO RECORDING ENDED]

PROFESSOR ROBERT MATTHEW LOVE, PREVIOUSLY AFFIRMED

DR ROBERT MARK HUTTON, PREVIOUSLY AFFIRMED

MS NARELLE LEANNE MILLS, PREVIOUSLY AFFIRMED

PROFESSOR HIEN CHI NGO, PREVIOUSLY SWORN

EXAMINATION-IN-CHIEF BY MS WRIGHT

MS WRIGHT: Professor Love, could you please state your full name for the Commission?

PROFESSOR LOVE: Robert Matthew Love.

MS WRIGHT: And you are the Chair of the Australasian Council of Dental Schools?

PROFESSOR LOVE: That's correct.

MS WRIGHT: Is ACODS the peak academic body in Australia for dental education and research?

PROFESSOR LOVE: Yes, it is.

MS WRIGHT: Are there nine universities offering degrees leading to eligibility to apply for registration as a dentist in Australia?

PROFESSOR LOVE: Yes, there are nine in Australia, yes.

MS WRIGHT: And a number of other universities and bodies including TAFE offering qualifications in the other dental professions such as oral health therapy?

PROFESSOR LOVE: Yes, there are a number of other ones. ACODS has four other representatives from TAFEs or other universities that are slowly providing education therapy or hygiene level.

MS WRIGHT: So ACODS' members include all of the education providers providing courses of study leading to any of the dental professions, that is not just limited to dentists?

PROFESSOR LOVE: No, it's not limited to dentists, no. It's got the other professions as well.

MS WRIGHT: I see. Thank you. You're also the head of school in the School of Dentistry and Oral Health at Griffith University, is that the case?

PROFESSOR LOVE: Yes.

MS WRIGHT: Dr Hutton, if you could state your full name for the record, please?

Can you hear me, Dr Hutton?

DR HUTTON: I'm sorry, I was muted. Robert Mark Hutton.

MS WRIGHT: And you're the President of the Australian Dental Association?

DR HUTTON: That's correct.

MS WRIGHT: Is the ADA the peak national body for dentists and dental students?

DR HUTTON: Yes, it is.

MS WRIGHT: Do you practice dentistry in South Australia?

DR HUTTON: I do.

MS WRIGHT: You've been actively involved in the ADA both in the federal executive level and in the South Australian branch for many years, is that the case?

DR HUTTON: That's correct.

MS WRIGHT: Approximately what proportion of dentists are members of the ADA?

DR HUTTON: Approximately 70 per cent of Australia's dentists are members of the ADA.

MS WRIGHT: Thank you.

Ms Mills, if you could please state your name for the record.

MS MILLS: Narelle Leanne Mills.

MS WRIGHT: You're the Chief Executive Officer of the Australian Dental Council?

MS MILLS: That's correct.

MS WRIGHT: Is the Australian Dental Council the Australian accreditation authority for the dental profession under the National Registration and Accreditation Scheme?

MS MILLS: Yes, it is.

MS WRIGHT: Does the council have responsibility for accrediting the various education and training programs leading to registration as well as in developing and setting the standards for dental practitioner programs?

MS MILLS: Yes, that's correct.

MS WRIGHT: And you have previous experience in the health, education and accreditation sectors more broadly beyond dentistry?

MS MILLS: Yes, I was formally the CEO of the Australian Physiotherapy Council prior to this role.

MS WRIGHT: Thank you.

Professor Ngo, if you could please state your full name?

PROFESSOR NGO: My full name is Hien Chi Ngo.

MS WRIGHT: And you are the Dean of the University of Western Australia Dental School?

PROFESSOR NGO: That's correct.

MS WRIGHT: And the Director of the dental hospital associated with the university, which is called the Oral Health Centre of Western Australia, is that the case?

PROFESSOR NGO: That's correct.

MS WRIGHT: The UWA Dental School is the only tertiary training institution for dentists and dental specialists in Western Australia, is that so?

PROFESSOR NGO: That's correct.

MS WRIGHT: UWA offers a graduate, entry-level Doctor of Dental Medicine, the DMD, which is a four-year degree, is that the case?

PROFESSOR NGO: That's correct.

MS WRIGHT: And the Oral Health Centre attached to the university provides a training ground for the students in clinical practice, is that the case?

PROFESSOR NGO: Yes. You are correct, but at the top of it it act as a tertiary referral centre for the public dental health services.

MS WRIGHT: Referrals are made to the centre?

PROFESSOR NGO: Yes. So if a patient needs specialist care, they will come to the centre.

MS WRIGHT: Okay. And special needs dentistry is not currently one of the areas of speciality provided at that facility?

PROFESSOR NGO: We provide a limited service in respect to special need dentistry.

MS WRIGHT: Limited in what sense?

PROFESSOR NGO: We're starting - we're just seeing patients who are referring

down to us from the medical hospital because they have medical complications, and we have a unit providing service for those patients.

MS WRIGHT: I see. When you say it's limited, is it a limited range of interventions or is it limited, is it part-time in terms of the service or in what sense is it limited?

PROFESSOR NGO: Limited part-time for the time being, one day a week, and we're looking at expanding that in the near future.

MS WRIGHT: I see. For the benefit of everyone watching, it may be of assistance to define what special needs dentistry, it's a particular expression in the dental sphere, is it not? It's defined. Mark Hutton --- by the ADA and the Royal Australasian College of Dental Surgeons as:

> .... *dentistry that supports the oral healthcare needs of people with an intellectual disability, medical, physical or psychiatric conditions, that require special methods or techniques to prevent or treat oral health problems or where such conditions necessitate special dental treatment plans.*

Is that the recognised definition of special needs dentistry?

PROFESSOR NGO: That is correct.

MS WRIGHT: Professor Ngo, as the university doesn't offer a training program in Special Needs Dentistry, is that the case, consistent with the scope of practice of the oral health centre?

PROFESSOR NGO: Not at the specialist level. We are developing one.

MS WRIGHT: I see. And you're hoping to introduce a particular degree, a postgraduate degree commencing in 2024 in special needs dentistry, is that the case?

PROFESSOR NGO: That is the case.

MS WRIGHT: Presently, students wanting to go onto specialise in special needs dentistry have to access the postgraduate programs in the universities of Sydney, Melbourne, Queensland or Adelaide?

PROFESSOR NGO: That is correct.

MS WRIGHT: In terms of the primary graduate degree, which is the DMD, at the University of Western Australia, what is the exposure students can obtain to patients with cognitive disabilities during their four-year degree?

PROFESSOR NGO: During their four-year degree, there are three ways that they can be exposed. So we're focusing starting exposing them in year 3 and year 4, the last two years of the course. So they start with lectures, didactic teaching in the

course, then they attend communication workshops where actor will come in and guide them how to apply the head knowledge that they have just acquired, how to apply that when communicating with people with more difficulty. Then they have to complete clinical placement within the clinics of the dental health services, the public health clinics, and then we give them also observational placement. So in the previous placement they actually treat patients, and in this observational placement they only come and do observation.

MS WRIGHT: Are those clinical placements, are they for two weeks in the final year of their degree at the Fiona Stanley Hospital and then one additional day at the Shalom Coleman special needs clinic?

PROFESSOR NGO: That is correct.

MS WRIGHT: What evaluation of the learning outcomes is made of those clinical placements and against what standards are the students assessed in terms of cognitive disability?

PROFESSOR NGO: Our students do regular rotation in their final year into other clinics, outside of the schools, and we have a framework to provide standard assessment and feedback from supervisors? So we are appoint those people who work in that clinic as supervisors and they will try to standardise what and how they assess as the framework that they have to follow.

MS WRIGHT: Are the students' skills or competencies in caring for patients with cognitive disabilities evaluated and tested?

PROFESSOR NGO: That was one component of the full spectrum of assessment.

MS WRIGHT: And how does that occur? What is the form of the evaluation?

PROFESSOR NGO: Every clinical session that they attend to, that assessment is done every session. So if they have done 10 sessions involving this special clinic, and they have done 100 sessions in a standard clinic, then that will be --- proportionally, going to be considered as the overall performance.

MS WRIGHT: How does the university currently access special needs in the area of dentistry for teaching and developing its curriculum?

PROFESSOR NGO: It's very difficult at the moment because WA in Perth, we don't have a local training school. So a lot of general practitioners with special interests in it will train themselves up and act as the main service provider in this area, and that's the reason why we want to develop a proper training program so that we can --- people don't have to go interstate to get their speciality recognition before they come back and provide the service.

MS WRIGHT: Does the university, or the dental school, rather, involve people with

cognitive disability at all in the development of the curriculum or its evaluation or delivery?

PROFESSOR NGO: At the moment it's very limited, and we recognise that being, you know, that's something that we will work on to get more engagement in the future.

MS WRIGHT: One of the propositions which the Commissioners are looking at is Proposition 2, I wonder if that could be brought up on the screen --- you may have it in front of you, Professor Ngo --- that proposes the active involvement of people with cognitive disability in the development, evaluation and delivery of curriculum. What do you say of Proposition 2? Is that something that you agree with and consider that there would be potential for the university to seek to ensure that in the future?

PROFESSOR NGO: Definitely this can be implemented. We can engage into this sort of activity. However, at an institutional level we have to give freedom and flexibility on how to implement it. But we have a good intention that, yes, this is a good idea, and you notice that currently in - we already have a workshop, communication workshop where people with disability actually come in and train our student, so allow them to practice in communication already. So it's not like it's non-existent. I acknowledge that it is a good method to engage in it.

MS WRIGHT: Professor Love, you have said, I think, at paragraph 9 of your statement that the involvement of people with cognitive disability is not a feature of dental or oral health curricula presently, but ACODS does see value in that being introduced. Do we take it, then, that you would agree with Proposition 2, which was just on the screen and it could be brought back up if need be?

PROFESSOR LOVE: No, it's okay, I remember it. Yes, we would be supportive of that. At the moment we, you know, we have to abide by one of the Australian Dental Council's accreditation standards which requires us to have community input into all our training programs, so that would easily fit into that standard. Of course we have quite a few other communities that would have to partake in that as well.

MS WRIGHT: How could that work be done in a way that ensured that it was meaningful and not just a tick-the-box exercise?

PROFESSOR LOVE: Well, we would have to report and prove, demonstrate that it actually has been done to the ADC as part of the accreditation process. I would imagine most people, most schools will set up, for want of a better word, a committee, which would include members of the profession, other key stakeholders like employers, as well as the community membership with terms of reference, that again are fairly well stipulated by the ADC that they have to be involved with the development and monitoring of programs, so the curriculum and programs. So I imagine most schools would have - most schools do have some sort of committee that does that but it would be a formal committee that would then report into the school to implement them, and then again we have to report to the ADC to prove that

we are meeting that standard.

MS WRIGHT: Ms Mills, is the involvement of people with disability in curriculum development and/or delivery something that the Australian Dental Council looks at when accrediting dental programs?

MS MILLS: Yes, thank you. I think the introduction of the new accreditation standards that came into effect from 1 January 2021 are much stronger on this point. This is our criteria 2.2, which --- I'll paraphrase --- used to say must have external input into the program, into the curriculum design, but now goes to the explicit level of requiring consumer (patients') input into the curriculum design. So from 1 January, those standards are much stronger in what the ADC will be looking for in its accreditation and monitoring of programs ongoing. It's probably not sufficient anymore to just have an external advisory group, which was the general and usual way programs would be seeking that feedback. I would be seeking to see in evidence interactions, particularly with patients, consumers and families into the public sector that goes back into the program design, et cetera. So a much more system linkage of the different ways in which consumers can have a voice into the curriculum.

MS WRIGHT: Would you necessarily be looking in the consumer area for input from people with disability? Consumers could be a broad range of people. Would you be looking for the voice of people with disability in that?

MS MILLS: I think the ADC would be looking for that. We would be looking for a broad range of consumer voices, so people with disability, Aboriginal and Torres Strait Islander voices, rural remote populations, the schools in --- the placement of those schools are --- they should be integrated within the community that the students are working in, so we're looking for broad representation of the community with which that program is servicing through the students and through the practitioners that they're going to be developing at the end.

MS WRIGHT: But I take it there's no guidelines underpinning the accreditation standards which specifically require that the voice of people with disability be included in the consumer input on curriculum?

MS MILLS: It doesn't explicitly state in the standards or in the guidance notes who needs to be the voice of the consumer in that, no, you're right.

MS WRIGHT: If I could ask you about Proposition 1, which is about a competency framework for health professionals including for dental practitioners, and the relevance of that for dental practitioners.

Professor Love, you have said in your statement at paragraph 7 that disability is covered sufficiently in curricula where education providers comply with the ADC accreditation standards. For that view, are you relying on the mere fact of accreditation or are there other considerations which support your view that it is

currently sufficiently covered?

PROFESSOR LOVE: Accreditation is the main one, but we've all --- all the schools have implemented a curriculum which addresses a competency-type framework when it comes to the special needs area. It probably --- between schools, it won't be the same. Probably the outcomes at the end will be the same but the actual, how everyone gets there would be different.

So, you know, we covered it all in our special needs teaching. So all the schools will have that within their undergraduate program or the pre-registration program of dentists and also that will flow through to oral health therapists and hygienists as well. Also paediatric training as well. There's a heavy influence on any disabilities from paediatric because that's generally when a practitioner will initially start to see patients who need those requirements.

So within what's done within the general curriculums all around the country, there is a framework that does address it. We, of course, base our framework on that international standard as well, for example, you know, you can go to the UK and see what their standards is for - in the special professional bodies. So we base it on those international benchmarks.

So we do probably a lot of didactic teaching. The clinical teaching would be variable across the country because it really depends on how --- the patient pools between each of the various schools and where the patients come from. So most of the patients would be seen within a State service, for example, here in Queensland, Queensland Health, and via the hospital service. So it's a bit sporadic on the clinical aspects of treating patients.

But all schools send their final year students out on rural placements, for example Queensland, like we send them for six months into Queensland-run facilities where they can get exposed to the different patients. So that's one of the areas that we do. We're very keen and strong on doing that. And all schools have some sort of out-placement into the health system.

MS WRIGHT: When you said there is an existing framework, what do you mean by that? Is there actually a written framework setting out the competencies required in special needs dentistries?

PROFESSOR LOVE: Yes, yes, you will be able to find international ones. Within each school, whoever is running the program, the program or course in special needs dentistry, will have the various competencies required and mapped against what learning outcomes. Again, that's a requirement for the ADC accreditation, that we have to have competencies and then map how we measure them.

MS WRIGHT: Just in relation to those competencies, Ms Mills, we've referred to the accreditation standards which I note Commissioners are at tab 28, 26B of the hearing folder. The Dental Council has also developed what's called professional

competencies that new graduates are expected to meet, and the dental schools are required to, in effect, teach the professional competencies at the same time as complying with the accreditation standards. Is that how it works?

MS MILLS: That's correct. The accreditation standards are the program standards, so the structure of the program. The competencies are what the learning outcomes need to be mapped to, so programs have to demonstrate how they are achieving the graduate outcomes in their curriculum.

MS WRIGHT: There are no disability-specific competencies in the professional competencies document, nor the standards?

MS MILLS: They're not specifically referenced, you're correct. The curricula of all of the programs, and you do have two very skilled heads of school here, is a vertically and horizontally integrated curricula. So when we talk about communication and interprofessional education and patient-centred care, they're the foundations in the early years of the program that we're referencing back and the competencies around preparing dental students for practice with complex cases such as people with disability.

MS WRIGHT: The professional competencies have six domains. They are set out at tab 26D, Commissioners. The competencies have six domains comprising professionalism, communication and leadership, critical thinking, health promotion, scientific and clinical knowledge and patient care.

Just taking two of those, Ms Mills, communication and leadership, which is page 11 of the competencies, sets out the need for dental practitioners to be able to communicate and engage with patients to present clear information, and I won't read out the whole lot, but there does not seem to be anything about dealing with patients with communication impairments?

MS MILLS: That's correct. And the competencies, the competencies that you're referring to came into effect in 2016, and are currently under review in 2021. There were some items or areas of focus that came up in the accreditation standards review that came into effect in January that do relate to competencies more than accreditation standards, so what you're referring to in terms of communication with people with cognitive disability will be considered in the revision of the competencies this year.

MS WRIGHT: The competencies are currently dated 2016 and are they reviewed on a five-yearly cycle?

MS MILLS: Yes, they are usually reviewed in a set with the accreditation standards and the competencies so that they remain contemporaneous for what's needed in the population.

MS WRIGHT: One of the other areas of interest in terms of a potential competency

framework is the need for health professionals to make adjustments to their standard practices in delivering clinical care. Is it fair to say that is not an area addressed currently in the professional competencies? And I'm particularly referring to domain 6 under patient care, there doesn't appear to be a competency dealing with adopting standard practices?

MS MILLS: It doesn't necessarily use that terminology, but you're correct, it doesn't actually refer to the adjustments.

MS WRIGHT: Is that an area that you'd expect to be reviewed in the forthcoming review of the competencies?

MS MILLS: Yes, absolutely.

MS WRIGHT: Would you agree, Professor Love, that the professional competencies could better address the specific needs of people with cognitive disability?

PROFESSOR LOVE: Yes, I think, as you've clarified, that it would probably be a bit more detailed on that. But I think the principle the ADC adopt, back when they were done, it was enabling for education providers to be able to design and deliver programs and not be too prescriptive.

If I can briefly say, when you go through an accreditation, the people who are doing the accreditation are very experienced, and they know exactly what should be in a dental curriculum. And if the things are missing than what they expect, I imagine if they didn't see anything that had special needs dentistry in the curriculum, that would be highlighted in the report. I would imagine that the ADC would then make a condition that that should be in the program.

So I think, yeah, those standards - everything evolves. I think what you say would clarify that area.

MS WRIGHT: If it's not referred to, however, one couldn't be confident that it would be covered in the accreditation process, would you agree with that? I mean I think you referred to it as a matter of detail or prescription, but those topics don't appear to be dealt with at all.

PROFESSOR LOVE: Yeah, I guess technically, because if it's not specified there, that it could be overcome --- overlooked, but as I mentioned, people who are doing the accreditation, they know what they need to see in a curriculum, and if they don't see it then they will mention it.

MS WRIGHT: Professor Love, do you think a nationally agreed competency framework, or at least a competency framework agreed by all the relevant stakeholders in terms of dental education would assist the universities to determine if their course content is sufficient?

PROFESSOR LOVE: Yes, ACODS is very, very keen on having national standards with a number of aspects of dental education. For example, at the moment we're working on the national standards for Aboriginal and Torres Strait Islanders, so we will have a standard that will be applicable to the whole country which will feed into the ADC requirements. So, yeah, so we're very keen to have everything, have a national curriculum. We do it in some aspects of dentistry, for example, cariology, which is tooth decay. It's pretty much --- it's a standardised curriculum across the country because we have various subgroups that look at that and other associations and say this is what should be in a contemporary curriculum. So, yeah, we're very keen and happy to have national standards.

It would be to be fairly high - dentistry is fine but if it was also spreading into other professions like medicine and nursing and that, they would probably work better if there were higher level standards, then we could say yes, we can do this and this aspect here.

But to have detailed ones from multiple - to cover multiple professions may be a little bit more difficult for us to manage.

MS WRIGHT: You've said in your statement that you see value or ACODS sees value with working with a national organisation in this area to ensure that key learning outcomes are valid and appropriate. What sort of national organisation are you referring to and how, in your view, could a competency framework be developed, and who would be involved and indeed who would lead that work? It's a number of questions in there.

PROFESSOR LOVE: I guess we'd be looking for a peak body who could - to tell us what's required in a curriculum outside of dentistry. So I guess we'd be looking at an association that would represent the patients in that area. And if ACODS was running it, then we would set up committee, we'd probably have representatives for each school, and then have the - those experts from outside ACODS to feed in, and then develop a framework which would be completely familiar to all members of ACODS and all dental educators in how a framework should look and how you can roll it out within a program?

If we were doing it, that's probably the way we'd do it. I'm not sure whether the higher - you know, someone like AHPRA could do it but, again, it may be just trying to cover off too many professions in one, trying to get one area there. Again, if you're doing that, it has to be a very high-level curriculum, not down into detail there.

MS WRIGHT: Okay, so you see a role for ACODS to potentially lead that work as opposed to the accreditation authority or the Dental Board?

PROFESSOR LOVE: Yes, and I won't speak for ADC but I think we prefer to develop, we're the educators, we're the ones that know how to educate, so we'd be the ones keen to be involved in running that. I don't think, I don't speak for ADC, but

ADC doesn't necessarily want to get into prescribing curricula and also the Dental Board as well. It's probably not in their remit. But we would work with --- we're working with the ADC on the Aboriginal and Torres Strait Islander curriculum. We're doing it aside and then we'll, for example, we'll present it to ADC and see whether it meets their requirements. So that's the sort of thing that we could do.

MS WRIGHT: Professor Ngo, what is your view about a proposed competency framework that identifies core required skills for dental practitioners dealing with patients who have cognitive disabilities?

PROFESSOR NGO: I'm of the view that it's got to be spelled out rather than assuming that people would do it because you already have a standard. So a workshop of some form to look at how it can be implemented at a school level. Then, like Robert has said, we can then go back to AHPRA, Dental Board, and say "Well, this is what we propose to do, what is your interpretation? Does it fit in with the standard that you are governing?" But definitely instead of saying that it's fit into certain - some general framework of competency, I would actually mention the group so we can stay focused on that.

MS WRIGHT: You've identified, in your statement, some areas where the dental school is proposing to introduce additional content on the dental and oral healthcare of patients with cognitive disabilities. Has that been identified as a consequence of a curriculum review or in answer to the Commission's request for a statement or how was that ---

PROFESSOR NGO: No, that was a piece of work that's going to happen anyway, before the Royal Commission called us for submission. We recognise that there's a gap as far as special needs dentistry in our education system because we don't have a specialist training program in that. So I have been consulting with the public health system together with the hospital real nurse, and just to give you an idea, our centre is located in the main medical district of Perth. So children's hospital, women's hospital, all the general hospital, major hospital would have a real nurse here. So we want to relook at that and say if we can actually allocate more time, how can we best use those time.

COMMISSIONER ATKINSON: So, Professor Ngo, you were talking about introducing a postgraduate course in special needs dentistry, but now you're talking about integrating it into the undergraduate degree as well, is that what you're talking about now?

PROFESSOR NGO: Yes, that's right. We see that our education is vertically and horizontally integrated. So someone can start in - the undergraduate can start with the undergraduate program, grow an interest in the field of special needs, and then do some work in our hospital to gain more experience, consolidate that interest, and then one day decided "I want to become a specialist", so he adds another specialist training program that they can join.

COMMISSIONER ATKINSON: Professor, no doubt you've looked at the other universities that offer the postgraduate training in special needs dentistry, and do they have the same vertical pattern that students get more training in their undergraduate degree in dealing with people with cognitive disability, then it moves into the postgraduate degree?

PROFESSOR NGO: I have a confession to make. I have been working in the Middle East for the last eight years and I only just returning to Australia in the last seven months, so I'm not really familiar with what the other dental schools are doing. However, you know, we have some very keen, young individuals who have their heart into this area, and that's why we've been discussing in our school how can we help them develop it further.

COMMISSIONER ATKINSON: So Professor Ngo, you're probably very grateful you were allowed back into Western Australia!

PROFESSOR NGO: I think all the stars were aligned for me to come back at the right time!

COMMISSIONER ATKINSON: Indeed. Thank you.

MS WRIGHT: Dr Hutton, if I could bring you in. You've provided the Royal Commission with a range of policy statements made by the ADA on a range of areas, including the oral healthcare of people with disabilities as well as education and training. It's the ADA's position that education and training must match the oral health needs of the community. Is that the case? I'm referring to your policy statement 2.1, national oral health.

DR HUTTON: That's correct.

MS WRIGHT: And in your statement you say the ADA has long advocated for dental schools to provide more education on the oral and dental care of older Australians and those with disability through their programs. There are currently, as you note in your statement, only 20 registered specialists practising in this area of special needs dentistry in the entire country. That number seems to have gone up by only five since 2014. That indicates that the majority of dental care for this group of the population is provided by general dental practitioners. That's a fair statement?

DR HUTTON: Yes, I think so. Of course, there's a range of needs of those patients, and so some of the patients who general practitioners feel competent to treat, of course they would go ahead and treat, and some --- many general practitioners become very skilled and develop their skills in treating special needs patients. But in the end, there's often a need to refer to a special needs dentist.

MS WRIGHT: Does that tend to underscore the need to address the skills and competencies required in cognitive disability at the graduate or undergraduate level, given that so few generalists are going on to postgraduate study to enhance their

skills?

DR HUTTON: Sorry, I don't quite understand your question.

MS WRIGHT: Does the fact that there is an extremely low number of specialists in special needs dentistry, and that the bulk of the care is provided by general dentists, does that highlight the need to be training generalists in their primary degree on the health, the dental health of people with cognitive disability because they're not going on and getting those additional skills during postgraduate study?

DR HUTTON: Yes, it's very, very important that dentists graduate with those skills and so, you know, we are certainly happy to see undergraduates receiving good education in treating patients with special needs. There will always be cases, though, as there are in all fields of dentistry, where there will be a need to refer when the treating dentist assesses that the problem they have in front of them is greater than what they can treat.

MS WRIGHT: Is a dentist who does not have an interest in special needs dentistry or a specialisation --- and there's no universal dental care in Australia --- is that dentist free not to accept or see a patient with an intellectual disability?

DR HUTTON: I think - I mean every patient - a dentist needs to assess the treatment of every patient they see and decide upon whether or not they believe they have the necessary skills to treat them. And that's with everything that the patients come in with. So every dentist needs to assess every patient they see, and if they feel they can treat the patient then obviously they go ahead and treat them. If they feel that the treatment exceeds, you know, their ability to provide safe and effective and good treatment for the patient, then they would refer.

MS WRIGHT: How do they do that when there are only 20 special needs dentistry specialists, specialist dentists in the country, how do general dentists either know about appropriate referral pathways or find appropriate training or resources that might assist them so that they can be equipped to provide the care themselves? Is that an issue ---

DR HUTTON: No. So all - or I assume, all practising dentists in Australia would have a referral pathway to a special needs dentist. You know, it's well known in each State who those dentists are. Every dentist who graduates, of course, tends to have interests that they develop and many would - and many dentists develop an interest in treating special needs patients and upskill themselves to be able to treat many of them.

The advice is always available. Often, if a dentist has, you know, a special needs patient, and particularly in a rural and remote area, and don't have an easy path to referral, everyone, you know, tends to pick up a telephone and talk to someone to get advice. So there are plenty of pathways and plenty of advice available for dentists, I think.

MS WRIGHT: That's a positive. The ADA has very clear policy statements, does it not, that federal, state and territory government schemes for public funding of oral health services are underfunded, and that there is unmet need in the community for the treatment of individuals in disadvantaged groups, which is - and the ADA has a clear definition of that including people with physical or mental disabilities as well as policy statements that individuals with disabilities are entitled to the same level of access to oral healthcare services.

So while I think you've said general dentists do have referral pathways, is access to dental healthcare by people with cognitive disabilities a real problem in Australia?

DR HUTTON: I would think it would be. I don't know what the quantity of that - or the size of that problem is and I don't know that there's been a huge amount of work done to actually assess that need. And that would be really good to see some really good data on what the real need is.

MS WRIGHT: I think we're pressed for time, Commissioners. Might I just deal with one extra proposition, if I'm allowed. Proposition 11, just to get your views, perhaps Dr Hutton. If that could be brought up on the screen.

This is a proposition which is proposing a strengthening of opportunities for health professionals to access training and resources, establishing repositories for health professionals to be able to access training resources and tools regarding providing health care to people with cognitive disabilities. Being realistic about it, one can say things are a good idea but is that something that is feasible and needed among dental practitioners?

DR HUTTON: It's certainly needed and one would hope that it was feasible. One of the - so right now, though, there is a bit of a disconnect between primary health networks and dentistry because dentistry isn't part of the Medicare system so there are no linkages between the primary health care networks and dentists. So although the ADA is currently engaging with the Department of Health roundtable discussions on access and quality of dental services for people with intellectual disability. So we hope that could be developed.

MS WRIGHT: Thank you. Those are my questions, Commissioners.

CHAIR: Thank you.

Commissioner Galbally, did you have any questions?

QUESTIONS BY THE COMMISSION

COMMISSIONER GALBALLY: I'd like to ask Professor Love and Professor Ngo,

I was very taken by the clinic that you're establishing at the University of Western Australia, Professor Ngo, or whether it's already done because considering the issue of access, which sounds really very, you know, difficult in this area, that's one way to get a little bit more access.

So, Professor Love, is that going to happen in all dental schools, and would that be an issue for your organisation to promote that and ensure that that's part of all dental schools because that would be another way of getting more access, at least?

PROFESSOR LOVE: Yes, we would like to have more access to patients with disability. It may not necessarily have to be within a dental school, it would be also doing out-placements to, for example, Queensland Health, because that's where I am. Because that's where most of the patients are seen. There's not a lot of patients seen in private practice, I don't believe. It's mainly seen in those centres. So those sort of out-placements there.

The major thing also about patients with disability, it's not just having a specific teaching clinic, because teaching clinics would not be appropriate for people with disability, it has to be more of a one-on-one room rather than in an open clinic of, say, six bays, so that's why it's better if it could be done in partnership with one of the state-run clinics.

Just recapping, we believe that the dentists who come out with the basic competencies have the ability to do what Mark mentioned before about being able to examine and assess and decide whether they can manage a patient and therefore refer off, and that could either be special needs or paediatrics as well, paediatrics are well versed - paediatric dentists are well versed in managing children, in fact they used to before special needs they became more of a speciality, and the paediatric dentists often managed the adults with special needs as well. So that's another area there.

But if I could just go onto the training that you've asked about, into the postgraduate area, there are pinch points for ACODS and other organisations I have mentioned quite a while back, trying to get people more into the speciality. So one is having to have the right patients, so you've got to be associated with a tertiary hospital, a big hospital, really, to be able to do that because not only the patients go there, they've got to have the facilities there. So again, a single operatory --- and you may need to have things like rooms for conscious sedation or general anaesthetic to be able to do that, and you can't do that in private. And it's increasingly hard to do that within a dentist school now because the compliance costs of running a conscious sedation or certainly a general anaesthetic theatre within a dental school is impossible. So you have to go outside the organisation to do that. So that's one thing about patients.

The other one is we all have problems with getting the appropriately trained staff as well. As you've pointed out, there's only 20 registered specialists in the country. There are a few others who wouldn't be registered specialists but general dentists who have got a lot of experience in the special needs who could do it. But if you're doing a specialty program, then even though the ADC doesn't stipulate it, most of the

profession requires someone who is running that program to be a registered specialist in that area, and so that causes a little bit of a difficulty because we don't have many in the country and they're hard to get.

Another thing is trying to attract students into that training. Because the nature of the work is going to be based in the public system mostly, ie they can't go 100 per cent private practice when they specialise because the work's not there and the compliance costs, et cetera, so they have to have a public appointment into one of the hospitals or the HSSs around the country. So we've always advocated that there should be more input from those HSSs into establishing training positions within the establishments that we can teach into, we can give the academic stuff, but they're there, they've got the patients and they've got the resources to do it.

So we've advocated that for a long time, I know other bodies have as well. Otherwise it's very hard for graduate dentists to start thinking "I want to do special needs dentistry" because they've got all these barriers in the way. So that's one area I think would be nice to try and break down some of those barriers.

COMMISSIONER GALBALLY: So as well as Proposition 11, you would advocate looking at access, looking at all the barriers, offering more really fantastic resources through a research centre wouldn't resolve the problem of access, that that has to be dealt with as well?

PROFESSOR LOVE: Yes. Access and, yeah, and employment opportunities post-graduation. Because if you take on a three-year specialty program, you're talking a lot of private funded fees, it's a big expense. And then if you have very limited appointment prospects at the end of that, it's a deterrent.

CHAIR: Thank you. Commissioner Atkinson?

COMMISSIONER ATKINSON: Nothing.

CHAIR: Commissioner Bennett?

COMMISSIONER BENNETT: Just quickly, Dr Hutton, building on what Professor Love said, your submission also said that ADA recommended that mechanisms should be put in place to encourage increased enrolment in specialist training. Is there anything that you want to add to the points Dr Love made, to encourage students or to find a way to increase from 25, is that ---

COMMISSIONER ATKINSON: 20.

COMMISSIONER BENNETT: --- 20 specialist dentists?

DR HUTTON: No, look, I don't think I can add anything to what Professor Love said.

COMMISSIONER BENNETT: Thank you.

CHAIR: Thank you.

Professor Love, the nine dental schools at universities, are all those in capital cities or are some outside capital cities?

PROFESSOR LOVE: Some are rural. Charles Sturt -

CHAIR: That's at Bathurst, is it?

PROFESSOR LOVE: Yes, Orange area. There's La Trobe, there's Cairns.

CHAIR: La Trobe I rather thought was in Melbourne.

PROFESSOR LOVE: Sorry, North Melbourne, I suppose, yeah.

CHAIR: Perhaps East Melbourne, but anyway.

PROFESSOR LOVE: Or there's Cairns. So, yeah, pretty much capital.

CHAIR: Talking about access, how are dental services provided to rural and remote areas, and I'm particularly thinking about First Nations people who have relatively high levels of cognitive disability. How does that work as far as the dental profession is concerned?

PROFESSOR LOVE: I think the bulk of that is done through the HSSs and the various self-driven clinics that some of the people put up. But it's mainly done by HSS, Royal Flying Doctors Service. So we, as educators trying to get our final year students out into the community, they're the areas that we look at to try and find spots to place our students. And again, with a bit of work that we will be doing with the new standard from the ADC, that we will definitely have to be looking for those areas to satisfy that.

Over the country there's some areas that are doing well, but it's a little bit varied there. Again, the biggest problem is it's no use sending really one student out to one very remote area for education when you've got a class of 120. So our problem is trying to make sure we've got an even balance of education across the cohort. So, again, you need the facilities to do that. So you probably, you know, for good efficiencies you probably need at least six dental chairs, you can have six to 12 students going out there at any given time so they're assisting each other, and that's a good cost-effective way of providing that care.

CHAIR: Okay. Thank you. I'm just bearing in mind the time we've come to. I assume none of the other counsel appearing today have any questions of the panel?

MR COSTELLO: No, thank you.

MS FURNESS: No, thank you.

MS McMILLAN: No, thank you.

CHAIR: Thank you very much.

In that case, may I thank all members of the panel who have appeared this afternoon to deal with these issues concerning the provision of dental services to people with cognitive disability. We appreciate the assistance you've provided to the Commission including the statements and the evidence you've given today. Thank you very much.

THE WITNESSES WITHDREW

MS WRIGHT: If we could adjourn for five minutes to call the final witness.

CHAIR: Yes, we will break until 3.16 Sydney time, 2.16 Queensland time.

ADJOURNED **[3.10 PM]**

RESUMED **[3.16 PM]**

CHAIR: Yes, Ms Eastman.

MS EASTMAN: Thank you, Commissioners.

Our final witness this afternoon is Mr Simon Cotterell and he comes from Canberra. He's asked us just to mention that he's got to stand while he gives his evidence today which I said is perfectly fine from our side.

CHAIR: Yes.

MR SIMON BROOK COTTERELL, PREVIOUSLY AFFIRMED

MS EASTMAN: Mr Cotterell, if there's any discomfort at any stage, can you let me know, and if you need a break please let me know. Thank you very much for waiting while our previous panel ran over time.

CHAIR: And thank you very much for returning to the Royal Commission to give

evidence another time.

MR COTTERELL: Thank you.

CHAIR: I'm sure you've been looking forward to it, Mr Cotterell.

MR COTTERELL: Yes.

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS EASTMAN: I just want to confirm that you are Simon Brook Cotterell?

MR COTTERELL: Correct.

MS EASTMAN: And you are the First Assistant Secretary, Primary Care Division with the Commonwealth Department of Health?

MR COTTERELL: That's correct.

MS EASTMAN: You have provided previous statements to the Royal Commission including a statement dated 5 February 2020 in which you set out your professional background in some detail?

MR COTTERELL: Yes.

MS EASTMAN: For the purpose of this hearing, Public Hearing 10, you've provided a statement dated 23 February 2021?

MR COTTERELL: Correct.

MS EASTMAN: Commissioners, you have a copy of the statement in your hearing bundle for today's hearing at Tab 40, and I will be taking Mr Cotterell to his statement.

Mr Cotterell, can I ask you whether there are any amendments that you wish to make to your 23 February statement?

MR COTTERELL: I'd like to make two. In paragraph 15, which is on page 4, the second last word is currently "its" and I would like to change that to "his" decision because it was a decision made by the Minister, not the Department.

MS EASTMAN: Yes, understood.

MR COTTERELL: Thank you. And in table 2 which starts on page 5, which is a timetable for completion of the National Roadmap, there have been

additional - sorry. Apologies. Table 1 which starts on page 2, which sets out the roundtable and targeted group discussion for the National Roadmap, an additional discussion on dental health has been scheduled for tomorrow, 3 March.

MS EASTMAN: So that would be added into the table. Do you want to add it in between 24 February and 16 March dates?

MR COTTERELL: Yes, please.

MS EASTMAN: What would be the correct name or the full name that you want to describe the panel in terms of dental health tomorrow? Have you got a formal title --

MR COTTERELL: Yes, so, "Improving the dental health of people with intellectual disability".

MS EASTMAN: And that's scheduled for tomorrow so we would include the date 3 March 2021?

MR COTTERELL: Correct.

CHAIR: And I assume, Mr Cotterell, that the meeting that was scheduled for 24 February 2021 has in fact been held, has it?

MR COTTERELL: It has.

CHAIR: Thank you.

MS EASTMAN: So with those additions and the correction, are the contents of this statement true and correct to the best of your knowledge and belief?

MR COTTERELL: Yes.

MS EASTMAN: Now, Mr Cotterell, I thought the best way to proceed this afternoon is that there's a number of questions arising out of the statement that you've provided to the Royal Commission and while the particular interest for this public hearing is education and training of the health profession, you have very kindly responded to the Royal Commission's request for an update on the progress of the National Roadmap. And the Commissioners will recall, back in February last year, that you did give some evidence in relation to the National Roadmap, and the Department's proposals in advancing that roadmap and that was at a stage pre-lockdown and various interruptions to people's lives and work, with the COVID-19 pandemic.

One of the matters that you told the Royal Commissioners about back in February last year was that the Minister had written to the Medical Deans of Australia and New Zealand, the Council of Deans of Nursing and Midwifery, and the Australian

Medical Council, seeking to engage these groups as stakeholders in the curriculum development in relation to the health care and treatment of people with intellectual disability and you will recall that you provided to the Royal Commissioners copies of the Minister's correspondence, and also you told the Royal Commission that the then Chief Medical Officer, Professor Brendan Murphy, had written to the Council of Presidents of the Medical Colleges to seek their involvement as key stakeholders to enhance medical education and training in relation to the health care and treatment of people with intellectual disability.

So can I just start, in terms of the questions that I want to ask you about the Roadmap. Was the steps that you were intending to take in relation to the Roadmap put on hold throughout the period of the COVID-19 pandemic?

MR COTTERELL: The process was put on hold for several months, but I would consider we're still in the pandemic, so it resumed after several months. We stayed in close contact with the sector during that time, Julian Trollor and others are on the COVID-19 Disability Advisory Committee that was meeting very regularly, and when it became apparent we would start to have capacity to resume this process, we resumed it.

MS EASTMAN: And in terms of bringing together the round table that was initially, I think, intended for April last year, that second roundtable didn't occur until 2 November last year, is that right?

MR COTTERELL: That's right. If I could add, the original intention was just to have two roundtables and to complete the work. We've expanded and deepened the level of discussion in this process, so we're heading for three roundtables and a number of targeted discussions.

MS EASTMAN: And the tables that you just made the addition to in relation to dental health, which you've reproduced at paragraph 11 of your statement, that is intended to tell the Royal Commissioners what steps have been taken including the smaller working groups and their work outside the plenary roundtables, is that right?

MR COTTERELL: That's correct. The targeted discussions were intended to be smaller groups but in fact have attracted a lot of attention so they've almost been as big as the roundtable itself.

MS EASTMAN: And the specific smaller group dealing with curriculum development and healthcare for people with intellectual disability occurred on 19 November last year, is that right?

MR COTTERELL: That's correct.

MS EASTMAN: And that was one meeting that you didn't attend, Susan Wearne convened that meeting, is that right?

MR COTTERELL: That's correct.

MS EASTMAN: To the extent I need to ask you some questions about what happened at the meeting on 19 November and any outcomes from that meeting, including an issue about whether there was or wasn't con-- consensus, do you feel equipped to answer the questions in relation to the 19 November meeting?

MR COTTERELL: Yes, on the basis of the documentation only, but those issues have continued to be discussed in other meetings so I'm happy to try to address them.

MS EASTMAN: All right. First thing I want to ask you about progress with the National Roadmap is when you appeared before the Royal Commission in February last year, one question that arose was whether or not people living with autism were included in the National Roadmap or whether it was limited to a specific cohort of people with intellectual disability. And is it right to say that following your evidence, there has been some consideration given by the department to include people with autism as part of the National Roadmap?

MR COTTERELL: That's correct. If I could draw attention to paragraphs 14 and 15 of my statement, which are on page 4, I undertook to raise the issue with the Minister following that hearing and the issue was raised with the Minister, and the Minister decided that we wouldn't be expanding the scope of the National Roadmap for the health of people with intellectual disability process but the people with autism would be covered to the extent that they have, or considered that they have an intellectual disability.

MS EASTMAN: That's what I wanted to ask you is, not all people with autism will necessarily have an intellectual disability. The diagnosis or the way in which a person may describe themselves may be very different. So if we look at your paragraphs 14 and 15, is the Royal Commission to understand that it's only people with autism who have intellectual disability?

MR COTTERELL: Correct.

MS EASTMAN: Was that change necessary, because if a person has an intellectual disability and also has autism, wouldn't they have already been covered?

MR COTTERELL: They would have. I raised it with the Minister because I'd undertaken to the Royal Commission to do so.

MS EASTMAN: So really, there hasn't been a full inclusion of people with autism, and there really is no material change because somebody with autism who has an intellectual disability was already part of the roadmap process, is that right?

MR COTTERELL: That's correct. The Government has a number of programs that assist, or aim to assist people with autism and they have been the subject of a recent Parliamentary inquiry, and the decision was to keep that set of programs separate

from this program - this process.

MS EASTMAN: The second thing I wanted to ask you is about paragraph 16 of your statement, and it may just be that we need some assistance in understanding who the relevant committees and divisions and sections are.

You tell the Royal Commission that in late October last year, the Department of Health Executive Committee decided to provide additional resourcing for the health and disability interface section in your division. Can you just explain to us who or what is the Department of Health Executive Committee, and what is the Health and Disability Interface section in your division?

MR COTTERELL: So the Department of Health Executive Committee comprises the Secretary and the Deputy Secretaries of the Department, and it makes overall decisions on the direction of the department and resourcing decision. The Health and Disability Interface section in my division was established as a result of a restructure of my division to put resources behind where the Government's priorities were in July ---

MS EASTMAN: When did that restructure occur?

MR COTTERELL: In July 2020, the Government appointed a Chief Allied Health Officer, Dr Anne-Marie Boxall, who is one of the branch heads reporting to me and in her branch, the Allied Health and Service Integration Branch, we established a new section to get more focus to the health and disability interface, and a new section to give more focus to allied health. And that was initially a movement of internal resources in my division, and then supplemented with some additional resources as a result of the Executive Committee's decision.

MS EASTMAN: Is the Health and Disability Interface section a section that also works across other departments? I think we've heard your evidence in previous hearings and one of the issues that arose in Public Hearing 5 was the extent to which health and disability were working together, or at least aligned in terms of their particular policy objectives. Is that the purpose of the section?

MR COTTERELL: So a major purpose of the section is to work with the Department of Social Services, the National Disability Insurance Agency, the NDIS Quality and Safeguards Commission, and with disability stakeholder groups to talk about the health needs of people with disability, including people with intellectual disability, and to make sure that we are addressing those needs.

MS EASTMAN: When you're talking about additional resourcing, is that sourcing in the sense of additional staffing within that section?

MR COTTERELL: It was funding for additional staff. Because of the caps on the number of public servants that departments are allowed to employ, that's been put to some additional public servants and some contractors who are assisting with the

work.

MS EASTMAN: The next question I had concerns paragraph 17, and you've told us that Professor Murphy is now the Secretary of the Department of Health, and on 18 February this year he wrote to his counterparts in state and territory health departments seeking a high-level participation. Why was it that it took until 18 February this year to reach out to the state and territory health departments to bring them into the process of the development of the National Roadmap?

MR COTTERELL: That wasn't the first time that the state and territory governments had been engaged. Shortly after the first roundtable, the Department was approached by a number of state and territory health departments seeking to be involved in the process, and at that time we agreed that all state and territory health departments could be involved. What we observed over the successive meetings and through the COVID pandemic was a degree of weariness from all involved, so there was a lot of engagement with the state and territory health departments throughout the first few months of the pandemic; they started not to attend at senior levels or in as great numbers. So the letter from Professor Murphy was intended to make sure that as we get to the finalisation of this process we have high-level representation from states and territories.

COMMISSIONER ATKINSON: Sorry, I just want to ask a question to clarify. I wasn't quite sure what word you used. Did you say "weariness" or "wariness"?

MR COTTERELL: Weariness. There's a level of exhaustion that's apparent in these processes because they have been very intense for some time.

COMMISSIONER ATKINSON: Thank you.

MS EASTMAN: So at the present time is the situation with the Roadmap --- there's been the smaller group meetings, which is, as you say, have been growing, there's been some consultations with particular individuals or organisations, for example, Mr Simpson and the Council for Intellectual Disability. There's been a questionnaire that's gone out to the stakeholders to get their feedback on where are things up to at the present point in time and what, in effect, is their wishlist going forward. Is that right?

MR COTTERELL: I'm not sure I would describe it as a wish list but I think we are in the middle of the process. We tried to resume it in a structured way, and we're trying to get the most out of it that we can.

MS EASTMAN: It's the case, isn't it, that the Department is working on or may have completed an updated Roadmap that you want to take back to the third and final plenary on 31 March, is that right?

MR COTTERELL: The Department is in the process of developing a revised version of the roadmap in consultation with a small drafting - small, informal

drafting group, and I draw your attention to paragraphs 20 and 21 of my witness statement.

MS EASTMAN: That has a paragraph where you make specific reference to Mr Simpson and the Council for Intellectual Disability. Has the discussions with respect to the advocacy groups who work in the area of intellectual disability gone beyond Mr Simpson and CID? Have you reached out to other organisations or groups?

MR COTTERELL: I'm not sure of the answer to your question, but a large number of organisations have been consulted as part of this process. It's a relatively high profile process, the discussions are attended by people with disability, their carers, their advocacies, organisations, there is very good and broad engagement.

MS EASTMAN: And by 31 March, is it the case that you intend to present a final version of the Roadmap to the final roundtable, and then that would cement the Commonwealth's way forward? There won't be any further changes? Is that right?

MR COTTERELL: We will present what we hope to be a final draft of the Roadmap to the 31 March meeting. That wouldn't be take it or leave it, it would be open to participants to suggest changes to it at that point. But we would want to finish the day with a draft that was acceptable to the group. If we don't have consensus on some issues, it may be that we need to point out different options, but I would hope that we could produce a consensus document, and then that would be for the Minister and - Minister to consider initially and then pending his decision, the government more broadly.

MS EASTMAN: So if the participants in the roundtable agree on a final version of the Roadmap, there's still the step of the Minister making a decision as to whether government will commit to the Roadmap, is that right?

MR COTTERELL: I think yes. So one decision is whether to commit to it. The other decision is whether state and territory governments will commit to it, and then there are decisions about funding for implementation.

MS EASTMAN: Because I can see, at paragraph 23, table 2, you've identified the period April to June this year to address the decision to implement any further steps including any continued consultation with the states and territories. Are we right in understanding that between April and June this year that the Commonwealth is looking to the states and territories to play part of the implementation of the elements of the Roadmap or is it something else that you are thinking about in that description - --

MR COTTERELL: So we sought to engage the states and territories throughout this process so that they are conscious of what's likely to be in the roadmap and won't have any surprises. And then the issue is escalated to ministerial level and the reference there is to whether and how the Commonwealth Minister for Health consults his state and territory colleagues and seeks their endorsement and/or

commitment to implementation.

MS EASTMAN: And the Roadmap is likely to have the time frames in the three areas, so the short term, medium term and then longer term, there's no intention to depart from that model, is that right?

MR COTTERELL: No, but it has changed slightly since the first draft in a couple of ways. So first to align it with the primary healthcare ten-year plan, the years are slightly different, so "short term" is defined as one to three years, "medium term" is defined as four to six years and "long term" is defined as seven to ten.

The second is, in the draft outline of the Roadmap, whole streams of activities were allocated to either short, medium or long term, and I'm expecting that in further drafts there will be a better staged implementation where we might be acting across all streams at each time point.

MS EASTMAN: It's the case, isn't it, that there will be arrangements for external oversight of the implementation of the Roadmap, and you tell us that in paragraph 25, that's what you anticipate?

MR COTTERELL: Yes, that's what I anticipate.

MS EASTMAN: Has there been any update since you prepared your statement on 23 February as to whether you can tell the Commission there will be arrangements for external oversight of the implementation of the Roadmap and if so, what does external oversight mean?

MR COTTERELL: So there haven't been further developments since my statement. The reason I include a little bit of uncertainty about it is because this would be a decision that the Minister and potentially other ministers might like to be involved in about what external oversight looks like, but it's my view that we need to have external stakeholders who are committed to this issue keeping the Department energetic and engaged with making sure that we implement this Roadmap.

MS EASTMAN: So "external" does not mean somebody outside the Department of Health but in somewhere else in the Commonwealth; "external" means independent, is that right?

MR COTTERELL: "External" means the set of stakeholders that we've been consulting on the development of the Roadmap, I would expect that some or many of those would be involved in external oversight of its implementation.

COMMISSIONER BENNETT: On that timeline, if all went well and Ministers and states signed off, it still wouldn't be in time for the next budget cycle of the Commonwealth and the states, would it?

MR COTTERELL: It's difficult for me to answer questions in this area because I

don't want to enter into matters that might be cabinet-in-confidence, but there is no intention, in that fourth row of table 2, to be avoiding the current budget process.

I think we included June as a month where we might be consulting states and territories, but I would hope that the Commonwealth might make decisions in May.

COMMISSIONER BENNETT: For a May Budget, but that would not necessarily mean states that might need to provide funding would miss the Budget --- the point that I'm trying to make is even if there's agreement on that timeframe and it requires additional resources, it would not be until mid-2022 that funding would be available. Is that a possible scenario?

MR COTTERELL: I don't understand state budget processes in as much detail, but I think some States have budgets earlier in the year, some states have budgets later in the year. I think any time that we can include the development of the Roadmap is going to lead to a long lead time for someone.

COMMISSIONER BENNETT: Does that then explain why your initial advice, that short term of one to two years is now one to three years?

MR COTTERELL: No. The only intention there is to align it with the primary healthcare 10-year plan.

MS EASTMAN: Can I turn now to the specific issue around education and training, and initially the Roadmap process was going to focus on medical and nursing schools, and it became apparent, didn't it, during the second roundtable on 2 November that the stakeholders, if I can call the participants that, thought that the discussion around curriculum development needed to go well beyond medical and nursing schools and to tap in more broadly to other health professions and allied health, is that right?

MR COTTERELL: Yes, allied health, pharmacy and dentists.

MS EASTMAN: When you talk about peak allied health, did you have a particular allied health profession in mind or were you talking about the peak representative body?

MR COTTERELL: Could you refer me to the paragraph?

MS EASTMAN: I'm looking at paragraph 27 and that's where you make mention of representatives from medical and nursing organisations participated, and then you say "Along with peak allied health, dental and pharmacy bodies" ---

MR COTTERELL: Yes.

MS EASTMAN: --- and the footnote tells us that there are a number of organisations listed there. What I'm trying to understand is when you use the expression "allied

health" what you do exactly mean by that? Do you mean just the peak bodies covering all forms of allied health or particular areas of allied health? What do you mean by "allied health"?

MR COTTERELL: So, allied health is a complicated area. There are a number of allied health professions that are regulated by the Australian Health Professionals Regulatory Agency, but they are not all the allied health professions, there are some self-regulating professions.

Some definitions of allied health include the physical therapies and exclude mental health professionals or exclude pharmacy or exclude dental. Some include all of those things. But I don't - we don't have any intention to be excluding any group.

MS EASTMAN: Looking at the list of organisations that attended, this is your footnote 3 on page 7, they are representative bodies in associations, is that right? They're not the regulatory bodies, you agree with that?

MR COTTERELL: That's correct. And -

MS EASTMAN: Mr Simmonds from the Pharmacy Board and Ms Phillips from the Psychological Board have told us in the evidence that they have provided to this Royal Commission --- paragraph 69 to 70 for Mr Simmonds and paragraph 78 to 79 for Ms Phillips --- that they were unaware of the Roadmap until they got a notice from this Royal Commission to provide evidence relevant to this hearing. So when you're talking about allied health, you're talking about the representative bodies but not the regulatory bodies. Is that right?

MR COTTERELL: That's who we've been consulting to date. That doesn't mean that we wouldn't engage with the regulatory bodies or the boards and various boards and councils to implement the Roadmap, but in developing the Roadmap we've been focusing on the stakeholder representative bodies.

MS EASTMAN: What about the representative bodies of various councils? There hasn't been formal involvement of those bodies into the Roadmap process, has there?

MR COTTERELL: Not to date, but again, we --- when we've reached a consensus on how to approach this issue and moving to implementation, we will be engaging them at that point.

MS EASTMAN: So at the meeting on 19 November which was the targeted discussion group on curriculum development in intellectual disability healthcare, and this is the meeting you didn't attend, but you've said in your statement at paragraph 30 consensus was not reached on the optimal approach because some stakeholders were advocating standalone programs, and other stakeholders were advocating embedding learning and training for curriculum in all aspects --- I'm trying to paraphrase paragraph 30.

What was the upshot of this inability to reach consensus in terms of how you've moved forward on the curriculum review and development?

MR COTTERELL: So we have decided we need to keep discussing the issue until we can find a consensus approach. At one of the other targeted consultations, this issue also came up. I had follow-up discussions with Professors Trumble and Prins from the University of Melbourne Medical School where they had their ideas where we could reach an acceptable outcome, and we'd been intending, through the remainder of the process, to try and get consensus on this issue.

MS EASTMAN: When you say consensus that rather suggests you're looking at an either/or approach. You either have standalone or you have embedded. What's wrong with pursuing both approaches at the same time? Would they not be complementary?

MR COTTERELL: So in my statement at paragraph 30, I used the word "mandatory", so it's the standalone mandatory that is the issue. I don't think there's any objection to having standalone units that people might elect to study, or if they were going to specialise in this area, being mandatory is part of the specialisation. I think the objection is to standalone mandatory units as part of undergraduate or other entry-level courses.

MS EASTMAN: The distinction is then between mandatory and voluntary. If you're talking about mandatory units of study, don't you have to include the accreditation bodies?

MR COTTERELL: So the Department is not advocating mandatory units of study, the Department is trying to find a consensus from the sector that we can put to the Minister and that is implementable, and the discussion with the sector is heading towards mandatory competencies being included in undergraduate and entry-level courses and voluntary units of study that people might want to undertake, and specialised units of study that people might want to undertake.

MS EASTMAN: So before you make a decision about which approach is optimal, as you say, who else needs to be consulted before you make a final decision?

MR COTTERELL: So if we head down this route of mandatory competencies and standards, then we will need to consult the Australian Health Professionals Regulatory Agency, the various boards and councils, and so those professions that are not regulated, the relevant professional bodies.

MS EASTMAN: And when would that happen, given the timeline that you've described in your statement?

MR COTTERELL: Well, it needs to happen quickly but we're not at that point yet.

MS EASTMAN: Can you understand that I've got a difficulty with the timeline that

suggests the final Roadmap by 31 March, but if you say that there's further consultation that needs to be taken with respect to the curriculum development of the Roadmap, that's a very short period of time to undertake what might be a very large consultative exercise before 31 March, would you agree?

MR COTTERELL: Yes, but I think, as I indicated earlier, we may not be able to reach consensus on all issues by 31 March, we might need to work some issues out during the implementation phase. And, we're intending to have an external body to help us do that including many of the stakeholders that have been involved in discussions to date.

MS EASTMAN: Would part of the consideration on curriculum development also look to the extent to which the Commonwealth would fund any review of curricula and development of curricula across the health professions?

MR COTTERELL: So the Commonwealth doesn't have direct legislative levers in this situation, so our --- the levers that we can use are persuasion and funding. And funding decisions are taken by the government in budget processes.

MS EASTMAN: I'm paraphrasing Professor Trollor's evidence, and you may have read his evidence from a period in this hearing last year. He has identified the absence of clear levers as one of the issues and persuasion seems not to have been particularly effective over the last 20 or 30 years. So is it just funding the Commonwealth can use as a lever here?

MR COTTERELL: Well, I wouldn't necessarily agree with Professor Trollor's view that facilitation and persuasion --- I've added in the word "facilitation" there --- facilitation and persuasion are not effective; throughout the period of the pandemic, facilitation has been a key role that the Commonwealth has played. There has been really good engagement with this National Roadmap process and a lot of goodwill, and I think there is goodwill to support change, and as I say, if there is funding available, that's a matter for the government to decide.

MS EASTMAN: At paragraph 34 you tell the Royal Commissioners that the final content of the Roadmap is subject to the decisions of the Minister and government, and do we take it that you undertake to provide the Commission with a written update later this year following further decisions on finalisation of the Roadmap and implementation? Is that right?

MR COTTERELL: That's correct.

MS EASTMAN: Could I take it entirely as an undertaking?

MR COTTERELL: Yes.

MS EASTMAN: The final questions that I wanted to ask you, and I'm mindful of the time, is you may have seen a copy of the propositions document, and some of the

propositions touch upon matters that are the subject of the roadmap and others not necessarily so. Are you able to say, on behalf of the Commonwealth Department of Health, whether the Department has any comments or views on the propositions?

MR COTTERELL: So I don't have the propositions in front of me, but I have read them. The Health Workforce Division in the Department usually meet on professional education, training and development issues, and I haven't discussed the propositions with that Division. But my view is all of the propositions are supportable.

MS EASTMAN: Thank you. Mr Cotterell, thank you for your time, I will just check now with the Commissioners whether they have any further questions.

CHAIR: Commissioner Galbally?

QUESTIONS BY THE COMMISSION

COMMISSIONER GALBALLY: I would like to bring up a question I asked in Public Hearing 6 and that's regarding people - it's regarding the First Nations scholarship schemes that the Commonwealth fund for First Nations people to do medicine, and whether there was a similar proposal for people with disabilities to do medicine, you know, if their entry was appropriate. And I would really just like to have that answered at some point. It clearly isn't in the Roadmap, but I wondered why not, if cultural change is what we want, from a Roadmap.

MR COTTERELL: Thanks, Commissioner. I can't give you a direct answer right now, I'm happy to take that on notice and come back to you.

CHAIR: Thank you. Commissioner Atkinson?

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner Bennett?

COMMISSIONER BENNETT: No, thank you.

CHAIR: Can I come back to the question of what's been happening during the pandemic, Mr Cotterell.

You will be familiar, no doubt, with the contents of the Royal Commission's report arising out of Public Hearing 5?

MR COTTERELL: Yes.

CHAIR: You will know, I think, that the report was presented to the

Governor-General on 26 November 2020 and tabled in Parliament on 30 November 2020. Are you familiar with more or less those dates?

MR COTTERELL: Yes.

CHAIR: You will remember, I think, that Recommendation 1 was that there be an early response from government to that report. Has there been any discussion of the report on Public Hearing 5 on the roundtable?

MR COTTERELL: In the roundtable process on disabilities?

CHAIR: In the roundtable process since 30 November 2020 when the report was tabled in Parliament?

MR COTTERELL: So we have a targeted discussion scheduled to learn the lesson from COVID-19 and for ---

CHAIR: A targeted discussion on the report or on COVID-19 generally?

MR COTTERELL: So there are two processes that have been running in parallel and they're confusing because we use the word "roundtable" liberally but there's been a roundtable process in relation to the health of people with intellectual disability and in my statement in table one we have a targeted discussion scheduled for 16 March titled "Incorporating COVID-19 implications into the National Roadmap" and that's intended to bring the COVID work into the intellectual disability area.

At the same time and throughout the pandemic, the Department has convened the COVID-19 Advisory Committee and a broader COVID-19 roundtable for people with disability and that roundtable and that advisory committee have both discussed various elements of the Royal Commission's report.

CHAIR: And are you aware of when there is likely to be some response to that report from government?

MR COTTERELL: That's a matter for the government.

CHAIR: Has the Department provided any kind of report on the COVID-19 report of the Royal Commission?

MR COTTERELL: Yes.

CHAIR: Thank you. Do any of the counsel present wish to ask any questions of Mr Cotterell?

MR COSTELLO: No further questions on behalf of the Commonwealth, thank you, Commissioner.

CHAIR: Thank you very much.

MS FURNESS: No, thank you, Commissioner.

MS McMILLAN: No, thank you, Commissioner.

CHAIR: Thank you. Thank you, Mr Cotterell, for returning to the Royal Commission and giving your evidence today and for your statement. Thank you very much.

MR COTTERELL: Thank you.

THE WITNESS WITHDREW

MS EASTMAN: Commissioners, that concludes the evidence for Public Hearing 10 over the three days of hearings and, Commissioners, I think you were going to make some directions in terms of ---

CHAIR: Yes, I have those in front of me. Do you want me to read through those or will you read through those?

MS EASTMAN: Well, these are the Commissioners' directions so I'm happy if you issue the directions.

DIRECTIONS

CHAIR: Good, thank you.

The directions that are made as a result of this Public Hearing 10 and, as Ms Eastman has just said, this is the third day of the hearing, the directions will be as follows:

1. By Tuesday 16 March 2021, any witnesses who took questions on notice during this hearing should provide their answers in writing to the Office of the Solicitor Assisting the Royal Commission. These answers should be targeted and concise.

2. Counsel Assisting the Royal Commission will consider any additional material produced and determine if any additional steps need to be taken. By Tuesday, 23 March 2021, Counsel Assisting will tender into evidence whatever additional material she considers appropriate.

3. Counsel Assisting will then prepare written submissions to the Royal Commission setting out the evidence that relates to the propositions which were examined at this hearing. The submissions may also include suggestions about further lines of inquiry

that could be pursued by the Royal Commission before recommendations might be formulated in relation to those issues. The material might also include proposed recommendations that may be made by the Royal Commission.

4. By 7 April 2021, the Counsel Assisting submissions will be made available on a confidential basis to those parties with leave to appear and the witnesses who gave written or oral evidence at this hearing.

5. Those parties who wish to make submissions in response to Counsel Assisting's submissions should do so in writing by 7 May 2021. The submissions in response should be concise and should not include any additional proposed evidence.

6. Following consideration of Counsel Assisting's submissions, along with any submissions received in response, the four Royal Commissioners who have sat at this hearing will prepare a short report on the hearing. That report will be made public in due course.

Those are the directions arising out of this hearing.

MS EASTMAN: Thank you, Commissioner.

CHAIR: Ms Eastman, did you want to make any statements finally or is that enough for the purposes of today's hearing?

MS EASTMAN: This has been a very long day and so the less I say at this point the better.

CHAIR: Thank you. I would just like to say that this, like all of the Commission's hearings, requires a great deal of preparation and organisation. This hearing has been a little different than other hearings that have been held by the Royal Commission in that we have been hearing from people involved in universities, in professional bodies, and certifying authorities in panels. Nonetheless, there is still a very large amount of organisation that is required and I want to express the appreciation of the Commissioners to the Office of Solicitor Assisting in the preparation of the hearing, to all of those who have contributed to the smooth working of this hearing.

On this occasion, we have had three Commissioners sitting in the one room and hopefully, very shortly, we'll be able to have hearings with Commissioners all present at the one time and members of the public permitted to join in --- at least to participate by being present in the hearing room. But in the meantime, much organisation goes into these hearings, and in this case Commissioner Galbally joined us from Melbourne and we express our gratitude to Law In Order for facilitating that and ensuring the hearing has proceeded smoothly.

There are others, of course, within the staff of the Royal Commission who have contributed greatly to the organisation and conduct of the hearing and we are very grateful to each and every one of them.

We'll now adjourn.

ADJOURNED AT 4.06 PM

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