TRANSCRIPT OF PROCEEDINGS

THE HON RONALD SACKVILLE AO QC, Chair
THE HON ROSLYN ATKINSON AO, Commissioner
MS BARBARA BENNETT PSM, Commissioner

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

10.00 AM, WEDNESDAY, 16 DECEMBER 2020

DAY 2

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

CHAIR: Good morning. I commence, as we always do, by an Acknowledgement of Country. I acknowledge the Gadigal people of the Eora Nation, the traditional custodians of the land upon which we are meeting today. I pay my respects to their Elders past, present and emerging, as well as respect to all First Nations people who may be viewing this hearing on the livestream.

Yes, Ms Eastman.

MS EASTMAN: Good morning, Commissioners, and good morning to everyone following the Royal Commission hearing, this is our final day of hearings for 2020. This morning we have a panel and I will introduce the panel members shortly, but before we move to the panel, I want to revisit some evidence which a witness who appeared at the public hearing in February, and Toni Mitchell and Joshy Mitchell have very kindly agreed at an early hour in Queensland to join us this morning. So I want to turn directly to Joshy and to Toni.

MS TONI MITCHELL

MR JOSHY MITCHELL

EXAMINATION BY MS EASTMAN

MS EASTMAN: Good morning, Joshy, how are you?

MR MITCHELL: Yeah, yeah.

MS EASTMAN: Nice to see you.

Toni, good morning.

We might start with formalities and I know that you have both been - Joshy, you can have a look at me, I will wave to you. So keep an eye on me. I'm going to ask Mum some questions. Okay?

Toni, welcome back. I think you have been sworn in before coming onto the screen. Can I just reintroduce you to people who are following this hearing who may not have met you or seen you give evidence and Joshy give evidence earlier this year. Can I confirm that you are Toni Mitchell?

MS MITCHELL: Yes.

MS EASTMAN: And your full-time occupation is a carer for your son Joshy?

MS MITCHELL: Yes.

MS EASTMAN: Commissioners, you received into evidence in public hearing four as Exhibit 4-6 a copy of Toni's statement.

Toni, I just want to go back over a few issues that you told us about in February.

Joshy, I hope you don't mind me taking about you, and let me know, but you have Down syndrome and Autism Spectrum Disorder and a number of other disabilities.

Joshy, that is right?

MR MITCHELL: Yes.

MS EASTMAN: And Joshy, you have had complex health problems since you were born. You had a significant heart problem that required multiple operations throughout your childhood, and you have had to have your --- part of your bowel removed when you were a teenager.
Joshy, you have had deteriorating lung conditions, so, Toni, Joshy has often had pneumonia and respiratory infections?

MS MITCHELL: Yes.

MS EASTMAN: Can I ask you at this point how has life been for the two of you during the COVID-19 period, particularly with the concerns you told us in February about your fear of Joshy contracting pneumonia or respiratory infections?

MS MITCHELL: I have been very closely following the virus outbreaks --- can you hear me?

MS EASTMAN: Yes, I'm asking the team to turn the sound up a little bit.

CHAIR: Yes, thank you.

MS MITCHELL: But pretty much since we got back to Sydney, we have not left the house. We have had two outings just in the last month but before that we hadn't left the house since February. It has been very restricted who has come into our home, so we have been very isolated.

MS EASTMAN: One of the issues we talked about when you gave evidence back in February is attending multiple doctor appointments in Brisbane or locally in Toowoomba. What has changed in terms of your engagement with doctors and attending clinics and various appointments?

MS MITCHELL: To start off with the appointments just got cancelled and then they slowly got changed over to being telehealth or just on the phone. So we have been doing that. If he has had to have --- in November he had to have a cardiology

appointment so we went locally to get the ultrasounds done, then that was sent remotely to the hospital in Brisbane, so we could have a phone consult instead of driving and being there in person so we have sort of adapted to doing it remotely.

MS EASTMAN: It is very nice to see both of you again. Toni, this hearing is about the training of health professionals, not just doctors but across the health professions. This is a topic that you talked about when you gave your evidence back in February. And the start with the health professions started with you before Joshy was born, and then immediately after his birth. But I want to ask you about diagnosis of Joshy's autism. That took a long time, and as a toddler, you raised with the paediatrician and the paediatrician also suspected that Joshy had autism but it was hard to get a clear diagnosis of his autism because of Joshy's intellectual disability. So when was Joshy confirmed with the diagnosis of autism and how did that come about?

MS MITCHELL: When he was nine, he was finally confirmed with autism and that happened because the traits of his autism became a lot more dominant than the intellectual impairment ones. They were very - they just became a lot more obvious and more easy to measure. They were able to confirm that.

MS EASTMAN: And you told the Royal Commission in February that you believe that Joshy has not and is not being treated properly, and has never been given the care or treatment he is entitled to. This has resulted in diagnostic overshadowing and Joshy suffering constant excruciating pain for many years because of ignorance, abandonment and neglect in the health system. So you have a fairly strong view, you expressed that back in February, and I want to explore why you have reached these fairly strong views. One of the reasons is that you have said over and over again, doctors and nurses don't respect your knowledge or anything that you tell the doctors and nurses about Joshy or his health.

MS MITCHELL: Yes. They - I have often been told "You are just a mum" so they dismiss any research that I have done. When I'm explaining his condition and the history of his condition and what is happening, they don't take on board what I do know and that I have done the research. They often - I have had the doctors come in and deliberately talk over me, so they are telling me something but they will talk in as complicated terms as possible and just talk over me and then say "Okay, so that's it" and get prepared to leave the room because they have done their duty, but they haven't actually discussed with me. I have to say "You need to sit down and talk to me", and once they realise I actually understand what they have been saying because I've been doing the research, then they will talk to me a bit more. But I often find I'm dismissed because I'm "Just a mum" and I'm not a doctor.

MS EASTMAN: We are going to hear - we heard yesterday and over the course of today about how important person-centred care is and person-centred engagement with patients and their families should be. What is your experience of person-centred care and what have you seen in terms of doctors delivering person-centred care?

MS MITCHELL: I feel - most of the time especially in paediatrics, Joshy was not seen as a person. They just looked at the Down syndrome. And didn't look at him as an individual. They did not look beyond the Down syndrome to see what was going on inside, and anything that we did present with would be dismissed as "Oh, that is just part of the Down syndrome. He is just being lazy. He has low muscle tone" without actually looking further and looking at him as an individual and looking at him within himself what was actually going on with his body.

MS EASTMAN: You have had to have a number of occasions where you have had to go toe emergency departments and hospitals, and you told the Royal Commission in February that once you arrive at the emergency department, then over and over again you were just passed over for the easier patients.

And it is very difficult, you told the Royal Commission, sometimes, to get attention at the emergency department, and what has been your experience of person-centred care on arrival at an emergency department?

MS MITCHELL: When we presented there, they have done the initial administrative detail and then they have just left him sit in the waiting room. We have sat there for more than eight hours just waiting, but the waiting room has emptied over and over again while weave been there because he is going to be difficult. And often times he needs to be admitted, and I tell them upfront "You are probably going to have to admit him for this", and so they just don't. He just sits there. He runs out of oxygen, he runs out of fluids, and we are still just sitting there waiting.

When we do finally get back into the back rooms, it is a very - it is not a good environment for Joshua. He doesn't cope with being in the back room because there are people crying and screaming and a lot of noise and bright lights and people just coming in and out and rushing past rooms. So, yeah, he does not cope very well with that environment to begin with, so easier for them to put him into a back room and just forget him.

MS EASTMAN: In terms of a physical environment and coping, in the evidence you gave to the Royal Commission in February, you talked about an example of having to go to Brisbane to get some testing done, and the experience when you arrived at the clinic where Joshy was not quite ready or settled, and he had a meltdown. And you reflect on that experience to say that health professionals need to understand how disability affects patients, and sometimes their behaviour or reaction to events and incidents. So there needs to be a certain way to talk to people with autism and making an adjustment. On that occasion that you went to that appointment, the nurse said, "Well, if you don't go in now, you are not getting the appointment", and the two of you left Brisbane and had to go back to Toowoomba but did not get the test that needed to be done and there was a pretty lengthy delay before you were able to re-book and go through that process again.

So what can you tell the Royal Commission when you say there is a certain way to talk to people with autism? What guidance can you give us and we will ask some

questions of the doctors coming up shortly, about techniques that work for people with autism, who are accessing health services?

MS MITCHELL: Okay. I would definitely say, you know don't just fire at them questions. You need to prepare, say "Okay, now we are going to ask you some questions", and not right there with crowds around them lined up. Maybe take them to a quiet place or a separate part of the counter where they can talk quietly. Ask simple questions, not a whole heap of questions at once, and give them time to process it and answer it, especially if they have the dual diagnosis such as Joshy, he has to have time to think about the question and process it before he can give out an answer. Oftentimes he will actually repeat it back to you before he will have the answer ready about, but then also with - we have gone into the room to see an ortho doctor, and the room was extremely small, so by the time the doctor was in there with his desk and I was in there, and Joshy's wheelchair came in, we could not shut the door so he was just in the doorway.

When the doctor turned around he had his hammer in his hand and swung around from his desk with the hammer up like this to immediately start doing Joshy's knees and Joshy just backed out of the door and took off. All he saw was a large man with hammer raised at him. So that is never going to work. You can't --- you have to understand how it appears to people that they are not going to understand what your motivations are and what you are doing.

MS EASTMAN: In 2015 you took it upon yourself to contact Toowoomba Hospital and ask whether you could come and run some classes for the registrars at the hospital?

MS MITCHELL: Yes.

MS EASTMAN: And the hospital agreed. So you and Joshy, together, go to the hospital and you run a class for the registrars. Can you tell us again what does that involve, and has it been successful?

MS MITCHELL: Yeah. Once a year we go to the hospital and run a session with the registrars and talk to them all about Down syndrome, specifically Down syndrome. We go into a lot of detail about Down syndrome and the body and all the different things that can happen with the body. Then we get them to look beyond the Down syndrome to the rest of the body and different medical conditions, also.

MS EASTMAN: How do you do that?

MS MITCHELL: I use a photo of Joshy, which I believe the Commissioners still have, where the original photo is of Joshy just fully dressed standing there. And I ask the doctors to tell me what they see, and they just see the Down syndrome and that's it. Then I turn the photo around and on the backside of that, Joshy is in his continence aids, and you can see his glasses, his hearing aid and his nappy, oxygen, scars, and such, and I ask the doctors "Okay, now what can you see?" And then they

start listing other conditions.

Then I ask them to tell me what they can't see and what else might be going on, like the autism and other things inside, and really getting them to think beyond the Down syndrome, because that is one of the biggest problems we have dealt in getting Joshy's diagnosis is getting them to look beyond the Down syndrome, and that has been very effective.

MS EASTMAN: The final words you said to the Royal Commission back in February were this "I should not have to be fighting. I should not have to be saying "It is more than the Down syndrome". I shouldn't have to be ringing over people's heads or calling in Ryan's Rule, I should not have to be doing this". Joshy should be treated as an equal as worthy as any other person should be".

And then I asked you about some suggestions you wanted to make to the Royal Commission, and you said you would love to see the type of class that you give at the Toowoomba Hospital to be part of a nationwide program. And you also said "Sessions like that should be run with everyone who works in healthcare" and you said that nurses need to have more or better training with autism, particularly managing meltdowns.

And your final word were "It can make a huge difference".

MS MITCHELL: Absolutely. It really can. There are so many gaps in the services, and in the training, that it is really important that disabilities be covered in more detail. Especially when - one in five people in our population has a disability, it should be something that is much more covered in their training across the board, not just doctors but the nurses and allied health circumstances as well. Joshy went in for a dental appointment at the hospital, and their way of holding him down was to put their arm across his throat and pin him to the bed. This isn't appropriate. And getting retraining people with security guards coming into hold them down on the bed so tests can be done. This is not appropriate, and it is not acceptable. Better training and better accommodations for people with disabilities so they can be treated without being hurt, and terrified, it has to get better. It cannot continue the way it is.

MS EASTMAN: Toni and Joshy, thank you so much for joining us this morning, reminding us of the evidence that you gave in February and sharing some further and new insights. I will just check if any of the Commissioners have any questions for either of you.

CHAIR: Thank you. I will first ask Commissioner Atkinson.

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner Bennett?

COMMISSIONER BENNETT: No, thank you.

CHAIR: Ms Mitchell and Joshy, thank you very much for coming back to the Commission for a second time. Not everybody gets to have a second run at the Commission, so thank you very much for coming back.

Ms Mitchell, thank you in particular for your thoughtful contributions and very firm but very helpful views to us. We do appreciate the work you have put into preparing material for the commission. Thank you so much.

MS MITCHELL: Thank you.

MS EASTMAN: Thank you very much to Joshy and to Toni.

We will now move to the panel, but I want to say something in introducing and opening the panel.

THE WITNESSES WITHDREW

CHAIR: Yes, certainly.

MS EASTMAN: I have three members of the panel, Associate Professor Beth Kotze, Dr Jacqueline Small, and Associate Professor Mitra Guha. In opening this panel we want to look at Propositions 1 and 9, and Proposition 9 concerns a certain specialist medical college training.

The Royal Commission has received evidence that enhanced trainings for specific medical speciality groups is required, and that key target groups should include general practitioners, paediatricians, psychiatrists, rehabilitation physicians and emergency physicians. Professor Trollor has said that for each of these groups it is recommended that improved training in these areas is incorporated into the basic training during speciality training. He considered that formal sub-speciality training capacity should be developed for general practitioners, psychiatrists and some of the specific groups of physicians. And he said that there is a need for scoping and feasibility of sub-speciality training, that is an essential first step.

Commissioners, you are aware that the draft national roadmap for improving health services for people with intellectual disability includes as one of its medium-term initiatives embedding training within all specialist training programs, including working with the medical colleges to develop curriculum for sub-speciality or the like in intellectual disability. At the Second Roundtable on the Health of People with Intellectual Disability held on 2 November this year, the attendees noted this: there is a limited supply of intellectual disability specialists, particularly for adults, and a greater need for improved training and career pathways for aspiring disability specialists.

The Royal Australasian College of Physicians is a professional medical college for physicians and training physicians in Australia and New Zealand. A person who want to be a specialist physician or paediatrician must complete the advanced training within the college. This consists of three years of basic training, followed by a three-to-five year advanced training program. You will hear shortly that while there are a large number of speciality areas, there is no training pathway or sub-speciality for intellectual disability or cognitive disability within the Royal Australasian College of Physicians, but you will hear that developmental and psycho-social training is a unique requirement for paediatric and child health trainees.

Dr Jacqueline Small, who I can see on the screen --- now the panel members are there --- is the President-Elect of the Royal Australasian College of Physicians. And you may recall she is a specialist paediatrician who has a particular expertise in intellectual disability and she gave evidence at public hearing four.

Now, Dr Small argued then and I will ask her if it continues to be her argument as President-Elect, that all practitioners should have a baseline level of skills, knowledge and awareness of the health needs of people with intellectual disability. She said further that there is insufficient inclusion in specialty and general practice curricula and relevant modules about intellectual and developmental disability.

She says that this impacts on the availability of appropriate healthcare for adults with intellectual disability.

Dr Small told you in February that training people to higher-level skills is achievable, and it must be achieved in the short to medium term.

In its statement to this Royal Commission, and Commissioners, you have a copy of the statement prepared by Professor Mark Lane, he is not giving evidence today, but in that statement the college has said that it supports the Commonwealth Department of Health's commitment to a national roadmap for improving the health of Australians with intellectual disability as part of the 10-year primary healthcare plan, and it sports Dr Small's contributions in that context.

Psychiatry is another area where there is an identified need to enhance training in cognitive disability in mental health, and the Royal Australian and New Zealand College of Psychiatrists's Fellowship Program involves three stages of training over 60 months. Stage 3 is a sub-speciality training, and the college offers seven certificates of advanced training in sub-specialty areas of psychiatry, but none specifically focus on intellectual or cognitive disability mental health issues.

A study, though, of psychiatrists in Australia and New Zealand in 2009, and you have a copy of the findings of this study at Tab 34 of Part B of the Tender Bundle, found that many of the college trainees regarded the training in mental health for people with intellectual and developmental disability as rudimentary, and they said

their training was significantly less than their overseas counterparts.

Most of those asked as part of that survey considered that the mental health needs of people with intellectual and cognitive disability would be best met by formalised sub-speciality training in intellectual disability and mental health. That study also showed that if sub-specialty training was introduced, and theres what a capacity in the system for rotations so that trainees could be offered the opportunity to work in intellectual disability sub-specialist training settings, that that would be appropriate.

At public hearing six you recall Dr Niki Edwards said that she considered that psychiatrists should be required to do a six-month rotation focused on intellectual disability during their training programs.

Dr Jane Law, you may also recall, giving evidence at public hearing six, recommended that there be formal recognition of a sub-specialty in cognitive disability with sufficient paid positions for psychiatrists.

The academic literature refers to there having been repeated calls for sub-specialty training in intellectual disability and mental health, particularly for psychiatrists, so the College of Psychiatrists has told the Royal Commission that they are "committed to continue to work with the section of psychiatry of intellectual and developmental disabilities for curriculum improvement including future development of a Certificate of Advanced Training", and further the board said it has a clear pathway for this development and one of the questions that we need to ask today is what is this pathway and when will this occur?

Before I introduce the three members of the panel, I might just put up on the screen - I will not repeat Proposition 1 which Commissioners you saw yesterday, but just put up Proposition 9, if that could come up, please.

You will see Proposition 9 is directed to specialist and sub-specialist training and the proposition is that medical colleges should review the curricula for general practitioners, paediatricians, physicians, including rehabilitation physicians and emergency physicians, anaesthetists and psychiatrists to determine what which further training is required by these health professionals. And, if a competency framework is developed, a review should be undertaken shortly.

So the panel now, and the panel that will immediately follow, will look collectively at these particular areas in terms of sub-specialty training.

CHAIR: Can I thank Professor Kotze, Dr Small, and Professor Guha for coming to give evidence. In Dr Small's case, welcome back to the Royal Commission. I will ask now Ms Eastman to ask you some questions.

ASSOCIATE PROFESSOR BETH KOTZE

DR JACQUELINE SMALL

ASSOCIATE PROFESSOR MITRA GUHA

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS EASTMAN: Can I start by introducing the panel, Associate Professor Kotze can I start with you. You graduated in medicine from the University of Sydney in 1982, and you are a Fellow of the Australian and New Zealand College of Psychiatrists, and you are also a Fellow of the Royal Australasian College of Medical Administrators?

A/PROFESSOR KOTZE: Yes, that is correct.

MS EASTMAN: And you have a Certificate in Child Psychiatry, a Master in Medicine in Psychotherapy and a Master of Health Administration and a Master of Arts specialising in French; is that right?

A/PROFESSOR KOTZE: That's correct.

MS EASTMAN: And you are currently the Director of Child and Adolescent Mental Health Services for the Sydney local area health district?

A/PROFESSOR KOTZE: Yes.

MS EASTMAN: You have held a number of executive and senior leadership and management positions for over 20 years?

A/PROFESSOR KOTZE: Yes.

MS EASTMAN: And your areas of clinical practice include perinatal, child and adolescent and youth help, psychotherapy, and you also have responsibility for impaired practitioners?

A/PROFESSOR KOTZE: That is correct.

MS EASTMAN: The impaired practitioners is a particular scheme under the National Law to manage medical practitioners or health practitioners who themselves have disabilities or impairments of different kinds, is that right?

A/PROFESSOR KOTZE: That is correct, I am involved in that scheme.

MS EASTMAN: And you have a particular interest in the training, education, and as

you say, the development of the next generation of psychiatrists?

A/PROFESSOR KOTZE: Yes.

MS EASTMAN: Can I turn to Adelaide, and I hope I'm right, Associate Professor Guha, that you are still in Adelaide?

I might need you just to --- they've changed the settings.

You are an Associate Professor and endocrinologist by specialty, is that right?

A/PROFESSOR GUHA: Yes.

MS EASTMAN: And you have served as the Chair of the Adult Division on the Medical Education Committee and the Chair of the Medical Program Curriculum Committee of the University of Adelaide?

A/PROFESSOR GUHA: That is correct.

MS EASTMAN: And you have also, as I understand it, had involvement with the College of Physicians in relation to medical, education and curriculum development?

A/PROFESSOR GUHA: Yes.

MS EASTMAN: I understand you have recently retired from full-time practice, is that right?

A/PROFESSOR GUHA: I have retired from my clinical profession, yes.

MS EASTMAN: But you still continue to have an interest in medical education, is that right?

A/PROFESSOR GUHA: Yes, I currently chair the College of Physicians Education Committee.

MS EASTMAN: That is a pretty significant committee.

A/PROFESSOR GUHA: It is.

MS EASTMAN: I can see Dr Small nodding.

Dr Small, you are now President-Elect of the College of Physicians?

DR SMALL: I am.

MS EASTMAN: The Royal Commissioners will recall your extensive CV.

Commissioners, you will find that as part of Exhibit 4-10 and in particular Exhibit 4-10.1 from public hearing four.

But just as a reminder, Dr Small, you are a developmental paediatrician with over 37 years of clinical experience?

DR SMALL: Yes.

MS EASTMAN: And since 2017 you have worked as the team leader of the Disability Specialist Unit within the NSW Sydney Local Health District?

DR SMALL: Yes.

MS EASTMAN: You have also worked at the Sydney Children's Hospital Network as a developmental paediatrician?

DR SMALL: Yes.

MS EASTMAN: Are you still the President of the Australian Association of Developmental Disability Medicine?

DR SMALL: I stepped down from that role in September because of the demand of the college.

MS EASTMAN: That is a role, though, that you held since 2015?

DR SMALL: That is right, and I remain on the Executive Committee.

MS EASTMAN: I want to remind you of some of the evidence that you gave to the Royal Commission back in February.

You told the Royal Commission this, "That people with intellectual disability are a minority group with significant health inequity", and when you refer to health inequity, you mean:

> *.... avoidable inequality in groups between groups of people that day rise from inequality from social and economic conditions. These can determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs.*

You told the Royal Commission that the available data shows that people with intellectual disability in Australia have a shorter life expectancy than those without intellectual disability, and those people died up to 20 years earlier than the general population. And you told the Royal Commission that 38 per cent of these deaths were potentially avoidable. You said "These alarming Australian statistics are also reflected internationally", and you expressed concern that people with intellectual disability have at least two and a half times the number of health conditions than the

general population, which meant that they are more likely to use a greater number of services including hospital services, but experience lower rates of health condition detection and poorer access to preventative healthcare.

You spoke about some of the complex health needs for people with intellectual disability, including limited verbal communication and reading skills, and generally the impact of communication in describing symptoms to help professionals understanding instructions, understanding drugs and giving consent.

You identified anxiety and distress in the patients with intellectual disability that can arise from communication impairment, and we just heard some examples of that from Toni Mitchell and Joshy Mitchell.

You said that people with intellectual disability attending specialised medical clinics in NSW were shown to have, on average, 5.4 medical disorders per person, and you identified particular concerns in relation to nervous system conditions, including epilepsy and mental health, respiratory system conditions, congenital conditions, oral health conditions and overall nutrition. And you expressed some concern that some of these conditions are often not detected and treated and contribute to the early cause of death.

At paragraph 34 of your statement to the Royal Commission, you emphasise the importance of training at all levels of medical training and beyond into practice. Is that a fair summary of some but not all of the evidence that you gave back in February?

DR SMALL: Yes, it is. There are some additional matters that I might like to draw out later.

MS EASTMAN: All right. In terms of the time that we have available, the approach I wanted to take with you all today is to just start with helping us understand the pathway to becoming a specialist, and we heard yesterday about undergraduate and graduate education in universities. We were told the curriculum is very crowded, that there is limited opportunity for students to have both a clinical experience, and also a theoretical understanding of intellectual disability and cognitive disability. But yesterday there was a fairly heavy emphasis that the undergraduate training is really just the basic tool, and that the real learning starts when someone is in practice, so let's start from a person who has completed their university studies and has now been registered as a medical practitioner under the National Law in Australia, and I will open this up to all of you: what happens to that person? What are their pathways immediately following graduation and before they might then decide to pursue a specialist course? Who would like to take that question?

A/PROFESSOR GUHA: Maybe I could start with that, because I've had responsibility looking after newly-graduated doctors.

After someone finishes medical school, they will need to spend a compulsory year as

an intern before they will get registration. As an intern they will work in a hospital and they will rotate through a number of mandatory rotations in medicine, surgery, emergency medicine. And at the end of that, provided they have taken that successfully, they will get full registration.

Most junior doctors at that stage will either go on to doing more hospital rotations in a generic way or some of them may choose, and if they are successful in being selected have, enter a specialist training pathway. So, for example, in our College of Physicians, most of the trainees who commence in the College of Physicians would have undertaken their internship and possibly one or two years post-internship before they commence a physician training pathway.

The different specialty colleges have different time frames, within their training pathways but if you take physicians and paediatricians, which is the one I know best, most physicians and paediatricians will spend the first three years of their training in what is called "basic training", and in basic training they will rotate through a lot of medical sub-specialties at various times --- all within hospital settings, largely --- and then they will sit the examinations of the Royal Australasian College in their third year of training.

They will then select to go into what is called "advanced training", which can be anything between three to five years depending on what the training program is. That will be either they can continue in a general direction to become what is called a general physician or a general paediatrician, or they can choose to sub-specialise in one of the branches of physician practice such as cardiology or gastroenterology or something in the various sub-specialties.

There is also a stream that is somewhat outside of this program but has its own program within the College of Physicians, such as rehab physician which is a four-year program, again after completion of internship and often another one or two years of general training. And then they will do rehab medicine.

There are also a number of other sub-specialty pathways within the College of Physicians, but the large majority will either go through the adult medicine training program or the paediatric training program.

MS EASTMAN: We would expect to see a young graduate is a year in a hospital setting, and during that year and then perhaps the following two years, that that graduate would then develop a particular interest in an area of medicine, and this is really an interest either, can I put it crudely this way, in a, not in a whole person but a particular part of the body, and organ or a disease, and essentially that the sort of specialties are very much geared around to particular conditions as you said, cardiology, rheumatology, endocrinology, the specialist areas of that --- perhaps with the exception of paediatrics and geriatrics where you are looking at a particular cohort based on age. Is that right?

A/PROFESSOR GUHA: Or general physicians. General physicians also have a

broader spectrum that they look after. I guess, yes, they tend to get focussed with specialised knowledge in a particular field.

MS EASTMAN: So that is physicians. Now, I have done my rotation and I think I might be interested in surgery or in dermatology or psychiatry, so, Dr Kotze, if psychiatry is something that a graduate is interested in doing, what is the pathway to becoming a psychiatrist?

A/PROFESSOR KOTZE: I think the first thing to say is it is absolutely critical, the exposure to psychiatry, intellectual disability as a medical student, and we find that there is strong continuity between interest at the undergraduate level that translates into seeking to be on the training scheme later.

So after completing an intern year, which there are very few opportunities for further training or rotation through psychiatry --- there are some but they are very few --- someone would then apply to join the training scheme in psychiatry. Once they are an accredited trainee, there is a 60-month full-time equivalent training scheme that involves a variety of structured experiences, the first being an acute adult, where of course people with intellectual disability are one of the populations that are commonly encountered through community and inpatient services, and in that part of the training, there is some very pertinent but general exposure in the formal training and education course to the need of people with intellectual disability.

The second stage of training, there is higher level of specialisation with some mandatory rotations, and some that are elective to the trainee, depending on availability. And at that stage the curriculum becomes much more specific to the needs of the people with intellectual disability.

The final stage of advanced training includes the availability of seven certificates in advanced training, six of which have significant components dealing with the needs of people with intellectual disability. At this point in time, a specific advanced certificate in intellectual disability just is not one of the offerings.

MS EASTMAN: I might come back to ask you a few more questions about some of those pathways and the nature of training in a moment, but Dr Small, can I ask you this: do the colleges have any role to play in the curriculum taught within the medical schools at university?

DR SMALL: The medical colleges don't have a direct role in the curriculum that is taught at university. As you heard yesterday, the AMC is the overall guiding body that we report to regarding our curriculum at a medical college level, but also at a university level.

MS EASTMAN: And you have mentioned the AMC there, it is the case, isn't it, that for both the College of Psychiatrists and the College of Physicians that any training program offered by those colleges also has to be accredited through the AMC?

DR SMALL: Correct, and the other medical colleges as well.

MS EASTMAN: And that process of accreditation requires the colleges to submit their particular training programs, and that includes not just the content but also the form in which a trainee will be assessed. Also the nature of the way in which the trainee will be educated in the workplace settings, and a number of other criteria that have to be met for accreditation, is that right?

DR SMALL: Yes, it is an extremely rigorous process that is an ongoing process for the medical colleges. Yes, they look beyond the specifics of the curriculum as well, for example, the AMC has recently been very interested in the consumer advisory group that has been established when the RACP, also in the Indigenous Strategic Framework, so they form part of the what the AMC looks at. If you would like further details I think Professor Guha would be well-placed to provide those.

MS EASTMAN: You have all talked about the pathway being someone decides that they want to become trained as a specialist lot. Can they just say "Look, I think I would like to be a paediatrician" and that there is an automatic entry to paediatric training, or is there a filtering-out process or a particular set of criteria to who even gets in the door for commencing a training program?

A/PROFESSOR GUHA: Most training programs have a selection process, so almost all of them have a selection process, and applicants are invited to apply for training in a particular discipline, and they will then be taken through the selection process and interviewed, often involving interviews, sometimes also involving written and situational judgment-type cases, but there is always a selection process to get into a training program.

MS EASTMAN: What sorts of things are you looking for in the criteria that will make somebody the type of the candidate that you want to take on a specialist pathway? What type of person are you looking for?

A/PROFESSOR GUHA: Right. I think that depends largely --- each individual training program will have its own criteria, so a criteria for a surgeon may be somewhat different for a physician or psychiatrist. So there will be different criteria. I can perhaps speak best to the selection process of physicians because I've been on a number of selection committees for that. I mean, we're looking at people with the capacity to think laterally and think broadly. We are looking at people who have got very good communication skills, who have got intellectual curiosity and the capacity to look beyond the obvious, and people who have resilience and can deal with complex and difficult situations, and people who have keen interest in looking after patients' best interest regardless of who the patient is, that you are looking at the patient as being the focus of your attention and looking beyond the disease, at the person that is behind that disease.

MS EASTMAN: It sound good in theory. How do you work that out in practice?

A/PROFESSOR GUHA: It is a good question. There are different methods of doing it. As I said, situational judgment types of tests are being used, increasingly so, and the College of Physicians has now developed a set of parameters looking at selection criteria.

We often use scenarios that we will give to our candidates and ask them how they would deal with various scenarios. But inevitably, in much of this there is elements of subjectivity involved, of course. We also rely quite intensively on referee's reports and reports from supervisors to tell us that they have the skills that we are looking for.

CHAIR: If I may interrupt, how does each college determine the number of applications who will be admitted to the program each year?

A/PROFESSOR GUHA: I cannot answer for all colleges, because I do not know the answer.

CHAIR: No, the ones you are familiar with.

A/PROFESSOR GUHA: It is based on the number of positions that are available. Most training --- apart from general practice, most training takes place in hospitals, and so the number of people who are selected in will depend on the number of positions available in hospitals that are funded for training positions.

CHAIR: To carry on from Ms Eastman's question relating for example to paediatricians, is the entirety of the training program for paediatricians necessarily carried on in a hospital environment?

A/PROFESSOR GUHA: A significant proportion of it is, the vast majority of it is. There are some community terms that are required by paediatricians, but that would be the smaller component of their training. The majority of their training will be hospital-based.

CHAIR: And who determines the number of slots that are available in hospitals, for example, for those who wish to train as paediatricians?

I'm sorry, I have just been reminded, if you don't mind, to remember to speak a little slowly because we have to interpret both through Auslan and for real-time transcript. You are not the only ones for whom the advice has been given, it is an endemic problem including among Commissioners.

A/PROFESSOR GUHA: Thank you, Commissioner.

The number of positions in hospitals are usually determined by hospitals and determined by the funding that the hospitals have for training positions. The college has very little influence in the number of positions in hospitals.

CHAIR: If I can just ask one more question before Ms Eastman gets angry with me, who makes the decision to admit or not admit someone?

A/PROFESSOR GUHA: You mean a trainee?

CHAIR: Yes.

A/PROFESSOR GUHA: Right, it will be a selection panel, and the selection panel is usually made up of a composition of Fellows of the training programs and sometimes administrators within the hospital.

CHAIR: One more --- there has been ---

MS EASTMAN: I can see Dr Kotze and Dr Small both ready to jump in.

CHAIR: Just before Dr Small comes in, though, and this may be a more general issue than we need to get into, but I know there has been criticism in the past of the criteria applied in practice because it is the people who are already in the system who are determining who gets into the system, and I just wonder if at some stage, not necessarily now, you might address that particularly from the point of view of practitioners who may have an interest in intellectual disability?

Dr Small, I think you wanted to say something?

DR SMALL: Thank you. I was wanting to expand on a comment that Professor Guha made in relation to the specialist training program, which is a federally-funded training program which aimed to diversify opportunities for training, and that was one of the mechanisms of enhancing community-based and flexible training within our health systems, or outside our health system for trainees, so that is a federally-funded mechanism that is potentially very relevant to what we are talking about today.

MS EASTMAN: Dr Kotze, did you want to jump in on any of those questions from the Chair?

A/PROFESSOR KOTZE: Sure, I just wanted to confirm that for the College of Psychiatrists, the intake procedure is very similar. To become a trainee in psychiatry you need to be accepted on the training program which is managed by the college and the college accredits training positions and training schemes, but you also need to be in a funded position employed by the jurisdictional health system.

I think that is important to note because the variety of experiences that somebody who might wish to sub-specialise intellectual disability and mental health will be impacted by the jurisdiction in which they work, so that for example, in NSW, whilst there is not a college sub-specialty advanced certificate, there are a variety of training experiences that are available because they are funded through our HETI, Higher Education Training Institute, and also a variety of experiences that are facilitated

because they are identified supervisors working within services who have specialised in intellectual disability.

So the States are actually a very significant third player alongside the universities and the colleges in what actually happens in terms of advancing specialist training.

MS EASTMAN: If a young graduate has done the internship at the hospital and she decides that she wants to become a specialist in intellectual disability and cognitive disability --- and just take out of the cognitive disability, dementia for a moment --- it is the case, isn't it, that there is no pathway available to that person to become a specialist physician in that area? And for psychiatrists, there may be one or two places open every year for a person who may want to develop that particular expertise in psychiatry? That is right, isn't it? That is my reading of both of your respective statements.

DR SMALL: That is correct. As has been introduced already, training requires both a physician for training as well as a curriculum, et cetera, and the opportunity for a specialist training pathway. Within our college, as has already been mentioned, there are two pathways for adult medicine that exist, rehabilitation and general medicine, with rehabilitation being more well-developed in their curriculum in relation to intellectual and developmental disability.

As appeared in the statement before the February hearing, there are a number of elements of the curriculum that speak to intellectual disability, but our college recognises that we need to do more. There is already an enormous project underway enhancing and developing and reviewing the basic training program as well as advanced training, so it is a good opportunity for looking at further changes for advanced training in particular, but I think the other element is training positions --- and to the best of my knowledge, there is one rare position for a rehabilitation trainee in the country, and that is available in NSW. And I'm not aware of any training position in Australia for an adult medicine physician specialising who wishes to specialise in intellectual disability.

MS EASTMAN: When you say there is no training position, there is no position in a hospital with an experienced specialist to be - and I think you have used this expression --- "A contemporised master-apprentice model of workplace training". There just is no position and no particular area of specialty where a new graduate wanting to become a specialist lot in this area could go?

Why is that --- Dr Small, can I put it plainly to you, why is that the case, based on what you have told the Royal Commission in February about a low rate of health outcomes, higher rate of mortality, notwithstanding this is a small population, there seems to be something of a health crisis within that population? Why isn't there a sub-specialty that covers this area?

DR SMALL: The RACP does acknowledge that the Royal Commission has found on the balance of the evidence that there is systemic neglect of people with cognitive

disability, and we are committed within our organisation to addressing inequities, so we have started some work internally looking at curriculum and training pathways, but that will take a fairly extensive amount of consultation and engagement beyond our college as well, particularly involving people with lived experience of cognitive disability.

But as you've heard, on our own we are - we do not directly have responsibility for the training positions and I think that is a matter for the governments as well to be drawn into this discussion.

A/PROFESSOR GUHA: May I add something to that? I think Dr Small is absolutely right in the sense that we do not have a directed pathway or training of people with cognitive impairment, but if someone is interested in that pathway, there are a number of avenues that a trainee can take and develop skills in the area of looking after patients with cognitive impairment, and a number of sub-specialties have emerged within the college in recent years addressing special niche areas that were not previously covered, for example, adolescent health and the transition of health from paediatrics to adults, and a trainee with a particular interest in, for example, intellectual disability, would go through a number of pathways either in the paediatric realm, or in the adult medicine realm, but it is something that they would have to in a way create for themselves within those realms in getting specialist training in that.

The college programs are reasonably flexible in allowing someone to develop a particular niche area if they want to do so, but we do not have a specific pathway, and I guess ---

MS EASTMAN: Can I ask you this - if the model that you use is workplace training which is master and apprentice, without a master how does the apprentice develop these tools?

A/PROFESSOR GUHA: That is a very valid question. There are masters scattered across the country that do have those skills, and often you will find a trainee that will link with someone like that, so it is not impossible to do but it is not a straightforward pathway.

CHAIR: I think, Ms Eastman, if I can frame it in a way that I'm drawing from the question - there seems to be a serious structural impediment to innovation in the sense in which we are talking about with providing medical services attuned to needs of people with intellectual disability. There are structural impediments because you start with a hospital system, the way the hospital system is structured, the spaces that are available, and I understand the point that if someone is sufficiently determined, they may be able to navigate their way through the system to pursue their interest. But in order to be training people with specialist skills in treating the, dealing with people with disability, you have to, in some way, overcome the entrenched structure of the system, don't you?

DR SMALL: Can I make a comment? I would agree with you. There needs to be training positions. Training positions in hospitals are funded by the States. The specialist training program that was funded by the Federal Government allows for flexibility determined and influenced by their areas of priority. And so there are --- those are the two main programs for physicians and a paediatricians where training positions are made available. There are potentially a few other kind of boutique-type positions, but those are basically where the positions are. And you are right, training occurs on the job with the guidance and framework and curriculum standards, et cetera, that are determined by the college that are overseen by the AMC. There are a shortage of dedicated programs. I think we are talking about two issues here, one, are the competencies as you have outlined in Proposition 1, that all health professionals ought to have, and our college has developed substantially our professional qualities framework, but we also recognise more specific areas of adjustment need to be made to respond to the issues and concerns that you have been outlining through the Royal Commission, and that work has started, and we have developed a series of principles that reflect in part the propositions but go beyond that related to the context of our work.

What we are also talking about are the high level of skills the leaders in our profession, and yes, we do require specific training positions for that.

MS EASTMAN: I will ask Dr Kotze --- I can see you want to jump in, because Dr Small, you have taken me the next topic which is, without a specialist dedicated pathway, then I want to ask you all about for the general pathways. So the cardiologist, the neurologist, the paediatricians, what content is there for intellectual and cognitive disability in that general training. So that is my next question.

But Dr Kotze, you wanted to jump in?

A/PROFESSOR KOTZE: I did want to just comment from the point of view of psychiatry, and that is that I think we have had a strong leadership cohort of Fellows of the College, particularly on the Eastern Seaboard, Queensland, New Zealand and Victoria, who have, over time, developed up very specific training experiences and provided trainees very much in the model of master and apprenticeship. They are - the more in-depth experience. I think for us in psychiatry we of course specialise in a population that has tremendous disability, impairment and disadvantage, and many of whom will also have the double disadvantage of intellectual disability, and the focus that there has been on having that capacity built up across the workforce and the curriculum I have described, but also in the training opportunity, for example, afforded by HETI, which means that people working in child and adolescent, or in, say, forensic mental health can actually also undertake specific training in intellectual disability.

That needs to remain in place because of the prevalence of intellectual disability, for example, in the jail system, that dual specialisation is especially valuable. What is actually missing at the moment is that highly identified specialisation in intellectual disability in mental health, and that is the component that is being addressed through

the review of the curriculum, and the review of --- the faculty has sectioned an advanced certificate of training that is currently being undertaken by the college.

MS EASTMAN: I have reviews as another topic to come to. Can I come back to this question, that in the absence of specific specialisation for intellectual disability, when the Royal Commission reads the statements from both the colleges, both colleges tell us about the training that is available at that first stage training before the advanced training, and the exposure that students may have to intellectual or cognitive disability. So I'm not going to ask you for the detail of that, we have that, but one thing I could not see in your responses is how do you evaluate the effectiveness of that training at the base level or entry level into specialist training? How do you monitor if it is master and apprentice style, and how do you evaluate the effectiveness of the bits that go into exposure to people with intellectual or cognitive disability? Who wants to answer that question?

A/PROFESSOR GUHA: Maybe I could start the ball rolling. In basic training there are a number of assessment tools that are used throughout the training program, that the college has developed and which are used by supervisors at the hospital level to assess their trainees. Some of these are looking at competencies and some of these are looking at what are called entrustable professional activities. It is using some of these tools that we can assess if our trainees are fulfilling the type of skills and attributes that we would like them to have. These are done throughout the training, this is quite independent of the exam which is at the end in their third year, but throughout their three years of basic training they will be getting reports from their supervisors, core rotational reports, they will be filling in competency tasks and they will be undertaking these entrustable professional activities that are geared towards actually assessing their performance in a number of key attributes that we think might ---

MS EASTMAN: That process is looking at whether it is the particular disease or organ that they are developing the expertise. I'm asking you about assessing the capability and/or competence in a person-centred approach to a patient presenting with intellectual disability. So how do the things that you have described in the statement, about exposure to people with intellectual disability as part of the training, how can you evaluate the effectiveness of that in making the would-be specialist capable in meeting the healthcare needs of someone with intellectual disability? Sorry, that is a wordy question.

A/PROFESSOR GUHA: I understand. The entrustable professional activities are not based on disease-specific issues, they are based on the kind of attributes that we want physicians to have, so communication, taking consent, how do you prescribe things, how do you describe a process to a patient. So that communication and counselling and other such skills that are tested on that, and that is not disease-specific or specialty-specific, that is required that all trainees in basic training and in advanced training, there are some common attributes that all advanced trainees, regardless of the sub-specialty they are in, need to fulfil as well, as the specific things they need to do for their particular ology. But there are generic skills

that are important and are measured by the entrusted pathway activities that assess those skills.

MS EASTMAN: In psychiatry, is there a method for both monitoring and evaluating the extent to which training is available to the students, will allow the college to be satisfied that a psychiatrist has the competence and capability to treat patients presenting with intellectual disability?

A/PROFESSOR KOTZE: Look, there is a comprehensive framework, so the competency-based training was introduced to the College of Psychiatrists in 2012, and within that there are a number of important processes and structures.

Firstly, there is the developmental descriptors that support the competencies, and I understand the College made those available to the Commission. There is then the series of formative and summative assessments a trainee is required to undertake. A number of those involve actually directly observed clinical activities, so that is where a more basic trainee will be assessed on their ability to establish rapport, to conduct an examination, that takes into account the capacities and limitations of the person that they are working with, and also takes into account some of those other contextual issues that particularity Toni mentioned around environment and how a person is responding to their particular environment at the time.

The most salient activity occurs in the workplace between the supervisor and the trainee, and it is strongly based in reflective learning, so the trainee having the opportunity to review with the supervisor, their skill development and how they have actually conducted an interview or done things like engage with families, for example.

They are then subject to reports which are reviewed through the training committees at the jurisdictional level that flow up to the college. So each trainee's progress is monitored very closely, in fact over the progression of their training. That will be, of course, more specifically focused around intellectual disability according to the context in which the trainee is working, the patient before them, the family, et cetera.

MS EASTMAN: Does the College use the Intellectual Disability Mental Health Core Competency Framework which was developed in NSW with the Department of Developmental Disability Neuropsychiatry and the NSW Department of Health --- Commissioners, you have a copy of this behind Tab 45 in Part B, and that sets out, for example, on page 21, the top ten attributes for working with a person with intellectual disability.

So, Dr Kotze, so does the College use that core competency framework at all in assessing or evaluating or monitoring competency skills in trainee psychiatrists?

A/PROFESSOR KOTZE: Professor Trollor has provided detailed advice to the College on how the next iteration of the competency-based curriculum can be strengthened, and his advice in very large part is derived from the competencies.

The competencies were a State-based initiative and designed to improve the competencies generally across the mental health workforce, working across a whole variety of settings. It was not specifically targeting specialist medical practitioners.

MS EASTMAN: I want to ask you then, in terms of the competency manual, is that used at all by the College of Psychiatrists?

A/PROFESSOR KOTZE: The College has its own tools and manual, if you like, which derives from their competency-based fellowship. It does not use the specific tool developed by 3DN in NSW.

MS EASTMAN: I am pressed for time, and I am going to ask if I can encroach on morning tea for another 5 minutes, Commissioners ---

CHAIR: Why are you looking at Commissioner Atkinson?

MS EASTMAN: I am looking at all of you.

CHAIR: Yes, you can encroach for 5 minutes.

MS EASTMAN: The two topics I want to end on, I'm interested in the masters. The masters have obviously gone through a training program either recently but maybe even 30 or 40 years ago. What is the ongoing training and education for the masters, the specialist of the colleges in terms of intellectual disability or more broadly, cognitive disability?

Dr Small, you are the President-elect, you have to be across it, and Dr Guha I will ask you because you are on the education committee. I'm now interested in the masters, you might remember that Dr Guha spoke about this being targeted for ongoing education.

DR SMALL: Our college has a continuous professional development framework that is accepted by the AMC as a framework for continuing professional development, and that needs to reflect the scope of practice. There are a variety of the clinicians --- of the positional paediatrician, and they are able to meet those specific requirements in a variety of ways that are relevant to their scope of practice. So if a particular individual was practising in intellectual disability, or where a significant proportion of their practice with intellectual disability, it would be expected that they would be undertaking professional development relevant to that.

The college does provide a range of resources that are specifically addressing intellectual disability, and will commence a project next year to review what we have and seek how we may expand those to be relevant to the issues that have emerged through this Royal Commission.

MS EASTMAN: Does the College keep any data or records of its 26,000 Fellows? How many Fellows have actually undertaken, in the last, say, three to four years

ongoing education in relation to intellectual disability, regardless of the ology, so the either disease or organ to which they have specialty?

DR SMALL: I would have to take that question on notice, but my suspicion is that we probably don't keep those types of records. We are intending to identify members early next year who have an interest in intellectual and developmental disability and cognitive disabilities more broadly, as part of our work that we are looking to review our training programs, ongoing networking among our members and perhaps identifying more masters than we may appreciate that exist so we are hoping to identify those next year.

MS EASTMAN: I'm talking about the masters, for example --- I'm not picking on cardiology, but a cardiologist has a patient with intellectual disability, that cardiologist has particular expertise on all things to do with the heart, but also whether that specialist has undertaken any training in relation to patients presenting with intellectual disability. That is the sort of ongoing training I'm interested in understanding. Is that offered by the College? And I think you have taken on notice whether there are any records that would help us under the number of Fellows in the College who will have undertaken that type of ongoing education.

DR SMALL: We can see if we can provide that information to you.

A/PROFESSOR GUHA: May I address that question?

MS EASTMAN: Yes.

A/PROFESSOR GUHA: The advanced training programs, the entire spectrum of advanced training programs currently is undergoing curriculum renewal, and that is a piece of work that will probably take up to about five years because we have about 30 sub-specialties that are involved in that process. Certainly one of the things we will undertake to look into is to looking at developing modules that specifically deal with intellectual disability to be included as part of the generic modules that all ologies, all sub-specialties will need to master as part of their training. That is something that we are looking at developing in the future.

MS EASTMAN: Dr Kotze, in terms of psychiatrists, what is the situation in relation to ongoing education and/or training for patients presenting with intellectual or cognitive disability?

A/PROFESSOR KOTZE: In terms of qualified specialists, there is ongoing strong leadership from a cohort of senior and more newly graduated Fellows within the College. There is also some guidance that the CPD provided by the College is fairly general, and really allows Fellows to very broadly pursue areas of interest and up-skilling. But there are some certainly formal activities provided by the College in that area.

MS EASTMAN: And there is nothing mandatory for either of the colleges in

relation to ongoing education and/or training for physicians or psychiatrists in intellectual disability?

A/PROFESSOR KOTZE: So the framework of the CPD for psychiatrists is that there is mandatory domains and a mandatory level of activity, but within each of those domains, because of the huge variety of sub-specialist interest in psychiatry, people can choose within those domains a particular activity, whether that is military psychiatry, forensic psychiatry or disability psychiatry ---

MS EASTMAN: But nothing mandatory?

A/PROFESSOR KOTZE: Nothing mandatory to intellectual disability.

MS EASTMAN: Dr Small, can I come back to you with some final thoughts and reflections. Taking on the role as President of the College is a very heavy and significant responsibility; during the course of your term as president, do you expect that there will be any changes in relation to how physicians might start to think about better outcomes for their patients with intellectual disability?

DR SMALL: I have observed significant changes already, and I expect that will continue over the next few years. For example, I think the very significant transformation of our curricula and ways of training our trainees will go some way towards addressing the issues that have been identified through the Royal Commission. We are already planning to undertake and have commenced undertaking some specific work, looking at how we can include people with lived experience, and as we have seen this morning that is a very powerful motivator for change, as well as people with lived experience can often identify solutions as well as sharing the problems and how it really matters to them.

So we are looking to see how we can involve people with lived experience more explicitly and generally in the work of the college, particularly with training, but not just training; in our advocacy as well. We already have been advocating and will continue to advocate for health inequities including the unmet needs of people with mental and intellectual disabilities.

I'm already seeing change in the College. I think we recognise that we are part of an ecosystem and we would very much like to see broader changes in the health system as well that respond to particularly people with intellectual disability but all people with chronic needs whose needs are not being met well by some of the models of care available within the health system at the present time.

MS EASTMAN: Thank you all very much, also bearing with us forgoing a little bit over time, but we very much appreciate your contribution to the panel this morning. Thank you.

CHAIR: Yes, thank you. I will ask Commissioner Atkinson.

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner Bennett?

COMMISSIONER BENNETT: No, thank you.

QUESTIONS BY THE COMMISSION

CHAIR: I am going to intrude a little further, this may be characterised as a bubble but I will go ahead anyway.

One of the characteristics of the medical profession, and it's true of other health professionals to perhaps a more limited extent, is specialisation and compartmentalisation. Over many decades, for reasons that don't matter, I have had a lot to do with medical practitioners, hospitals, intensive care units, emergency departments and so on. There are some things that the medical profession does astonishingly well, and that is largely a product of specialisation and of course advancing knowledge.

But what we have got here seems to be a tension between the specialised knowledge that is required of specialties and to some extent all medical practitioners, and the general skills, capabilities, competencies, however you want to describe them, that really should cut across all aspects of medicine.

From what I have heard, and it is true, we have been looking at the specific issues of treatment of, care for people with cognitive disabilities and there are other categories of people obviously within the community who need treatment. But at the moment I find it a little hard, and this is really something I think that Professor Guha alluded to, I find it hard to see how the skills in treating people with intellectual disability can't be skills that every practitioner requires. Maybe one could say pathologists do not need it, but that may depend on whether pathologists are sitting in a room dealing with blood samples or actively engaged with patients, but would it not be the case that the capacity to treat, deal with, understand people with disability, must be something that all medical practitioners, regardless of specialty, must have?

A/PROFESSOR KOTZE: Yes.

DR SMALL: Our College would also agree with you, there are a number of aspects of the comment you have made, comments you have made there. So we would support a competency-based approach that acknowledges that all health professionals, not just medical practitioners, ought to have a common core level of competencies in order to manage and effectively treat people with intellectual disability and their carers, their carers are also impacted. But there may be some people who require higher levels of competencies because they are the masters, they are the teachers, they are the leaders within the health system, and that is what we

need to grapple with. Our college is very conscious that while sub-specialisation has brought enormous strength and growth in knowledge, there is also a place for people with complex needs to be managed by somebody with more general expertise. That has been maintained in paediatrics, and I think there is reason for growing the role of general physicians and rehabilitation physicians with a broad outlook with specialised skills with people with intellectual disability, but that is part of the tension about specialisation versus generalisation that our college needs to consider very carefully.

A/PROFESSOR GUHA: I agree with the comments entirely, and I think it is important that we need to look at both two levels: one is a skill set that everybody has, and then a specialisation skill set.

But I think one of the other important elements of looking after a patient with complex and chronic disorder, and that is both with cognitive impairment but many other chronic diseases, is the multi-disciplinary team approach, and there is now increasingly encouragement at both hospital settings and community settings, but certainly our college is very strong in support of this, is encouraging and skilling our trainees and our Fellows in multi-disciplinary work so that complex patients can be better managed in that manner, because I don't think any one person can actually deal with all the complexities that a patient may have.

CHAIR: Thank you very much, Dr Small, Professor Guha, Professor Kotze for dealing so frankly and openly with the questions that have been put to you. The conversation has been extremely useful and stimulating. We are very grateful to you for your contributions to the Commission, and please do not take any questions that have been asked as critical of any aspect of the medical profession, particularly any doctors who may have to treat me. Thank you.

MS EASTMAN: Thank you again to the panel.

Commissioners, if we can adjourn now for 15 minutes.

CHAIR: Yes.

THE WITNESSES WITHDREW

ADJOURNED **[11.29 AM]**

RESUMED **[11.49 AM]**

CHAIR: Yes.

MS WRIGHT: Before we move to our fifth panel, we are going to hear some short evidence from Virginia Howie. Ms Howie's statement is at Tab 5 of Tender Bundle A. She is a registered nurse and academic and has taught in the area of intellectual disability and inclusive nursing practices for a number of years.

CHAIR: Thank you.

MS VIRGINIA ANNE HOWIE

EXAMINATION-IN-CHIEF BY MS WRIGHT

MS WRIGHT: I understand Ms Howie has already given an oath or affirmation.

Your name is Virginia Anne Howie?

Ms Howie, can you hear me?

MS HOWIE: That is correct.

MS WRIGHT: Ms Howie, you are a registered - you are registered nurse and academic?

MS HOWIE: That is correct.

MS WRIGHT: You have a Masters of Clinical Nursing in the cardiac area from CQUniversity and a Graduate Certificate in Tertiary Education; is that right?

MS HOWIE: That is correct.

MS WRIGHT: You practised as a nurse for over 20 years in Queensland?

MS HOWIE: That is correct.

MS WRIGHT: You became a full-time academic?

MS HOWIE: About 10 years ago, yes.

MS WRIGHT: You are a lecturer in the School of Nursing, Midwifery and Social Sciences at CQ University for 10 years, is that right?

MS HOWIE: That's correct.

MS WRIGHT: You are now doing a PhD in the lived experience of registered nurses caring for persons with intellectual disability in the acute care hospital

context?

MS HOWIE: That is correct.

MS WRIGHT: At CQUniversity did you teach a unit of study called Inclusive Practice of Nursing?

MS HOWIE: That is correct.

MS WRIGHT: You wrote that unit and were the lead coordinator of it, is that right?

MS HOWIE: That is correct.

MS WRIGHT: Your teaching at CQ ended only recently in 2020, is that right?

MS HOWIE: Yes, in July.

CHAIR: I take it we can assume that CQ means Central Queensland?

MS HOWIE: Yes, that is correct.

CHAIR: For those of us who do not have the benefit of residing in that State, yes.

MS WRIGHT: Ms Howie, you are a member of PANDDA?

MS HOWIE: That is correct.

MS WRIGHT: And a number of other associations, the Australian Society For Intellectual Disability and the Australasian College of Nursing?

MS HOWIE: That is correct.

MS WRIGHT: I want to ask you about your course, the inclusive practice unit. Was that a compulsory unit in the Bachelor of Nursing at CQUniversity?

MS HOWIE: That is correct, it was directed at first-year nursing students.

MS WRIGHT: Was that taught over two semesters?

MS HOWIE: That is correct, there were two intakes.

MS WRIGHT: It included content on intellectual disability and other forms of disability, as well as health access issues for other marginalised groups, is that right?

MS HOWIE: That is correct, yes.

MS WRIGHT: I think you have said in your statement that to your knowledge, that

was a unique unit of study, and by that do you mean that you are not aware of a similar subjected or unit being taught in any other Bachelor of Nursing degree in Australia?

MS HOWIE: That is correct.

MS WRIGHT: Can I ask you, how did you come to be delivering that course? Did you propose to it the university, or were you invited?

MS HOWIE: I was invited. The School of Nursing had decided on the name already and they were looking for me to lead a course or a unit, so I just ended up being the lead coordinator for that unit. So I was quite happy.

MS WRIGHT: You have recently left the university, and I think you have said that this, the inclusive teaching practice course won't be taught, going forward, as a discrete unit. Is that right?

MS HOWIE: That is correct. Yes. Accreditation, Bachelor of Nursing curriculum, go for five years, they are accredited for five years and so the new batch of nursing curriculum at Central Queensland University is due next year. I was assured that the intellectual disability content would be in the next curriculum, but I do not know because I have left. I'm not sure.

MS WRIGHT: You have said that to your understanding the content of the course, the inclusive practice unit will be spread over the whole degree program, is that your understanding?

MS HOWIE: That is correct. The person that was leading the new curriculum did a PhD in curriculum design, and so that was why she thought that spreading it out over the three years was the best way.

MS WRIGHT: Is there any downside in your view into integrating that content over a whole degree what there than teaching it in one place?

MS HOWIE: I feel that it will get lost if it is taught over three years. I think - it is like any basic nursing course, at first year it ground nurses in the first year of their training in the theoretical side of intellectual disability or disability. But it is about attitudes as well, so I think it is important that it stays in the university course.

MS WRIGHT: Yours was a theory-based rather than a skills-based course?

MS HOWIE: That is correct.

MS WRIGHT: You have provided to the Commission some of the teaching resources, and Commissioners, one of the resources or at least a description of the content is found at Tab 7 of Tender Bundle A on intellectual disability.

Your course covered topics such as the research around intellectual disability, what is intellectual disability, that it is a diverse group of people. The hospital experiences of people with intellectual disability, the research about attitudes to people in that population, the research about communication, issues of capacity and consent, pain assessment, behaviour support, all of those facts and evidence base about why people with intellectual disability have particular needs and what they are.

Is that a fair overview of some of the content you thought in the inclusive nursing practice program?

MS HOWIE: It is just an introductory unit so there is far more to it than that, but in terms of trying to squeeze it into one module, that is as much as I could do without overloading the student with too much information. But it is just a beginning understanding of intellectual disability.

MS WRIGHT: Is your concern that if that is spread, that kind of theoretical content, over a whole degree, some of those theoretical underpinnings and the data might get lost?

MS HOWIE: That's correct. Yes, I think it is basically - depends on a champion like myself who wants to put it into the curriculum, if they have gone, like that is what happens, like myself, there is no one else to champion it, because it is a bit of chicken-and-egg, so if nurses have not been taught it they do not know how to teach it, so you need someone with a bit of expertise or knowledge to be able to teach or to know where to go to get the resources to put into the curriculum.

MS WRIGHT: One view that has been put to the Royal Commission is that if teaching related to cognitive disability is to be enhanced, it should cover all vulnerable populations, not just those with cognitive or intellectual disability. What is your view about that?

MS HOWIE: I think "cognitive disability" covers - it's such a broad umbrella term for so many different types of diagnostic diagnoses such as dementia or age-related cognitive disability. Being born with a cognitive disability is different, so I think it still needs to be specific to intellectual disability. And including autism spectrum disorder, too.

MS WRIGHT: Because there are specific needs that affect this population, people with intellectual disability and autism spectrum disorder?

MS HOWIE: That's correct.

MS WRIGHT: You draw attention in your statement at paragraph 42, the Registered Nurse Standards of Practice, and you have said that they contain only generic statements applying to all people, and in your view are not sufficient to ensure nurses have the skills, attributes and knowledge needed to provide quality care to people with intellectual disability.

And I think you have said at paragraph 76 that you consider that the Standards For Practice for both registered nurses and enrolled nurses should be amended to provide for reasonable adjustments? Is that right?

MS HOWIE: If had that could be done, yes. I think it would be easy enough to include it and then you could use the broad term "cognitive", because then it is not focusing on a particular group such as intellectual disability which the Standards are not about. So if you were to include the word "cognitive" it would cover a broad range of people, but it is important that nurses are aware that people with cognitive disability have the right to choose their treatment, choose which treatment that they have.

MS WRIGHT: You have said that PANDDA's Standards For Nursing Practice for people with intellectual and developmental disability go further than the registered nurse and enrolled nurse standards of practice. Those standards of practice - have you considered whether there is a need for a framework, a competency or capability framework for guiding education providers to identify whether their teaching content is adequate?

MS HOWIE: I think the PANDDA Standards could be used by people developing curriculum, definitely.

MS WRIGHT: And they could be incorporated into a broader framework for not just nurses but for other health professionals?

MS HOWIE: That's correct, yes. In a paper that I have just written, I'm waiting for it to be approved, we found that - sorry, could you just repeat that question?

MS WRIGHT: Just asking you, one of the things that the Commission is considering is whether there needs to be a competency framework for assisting education providers to identify what needs to be taught, what are the core competencies in addressing the health needs of people request cognitive disability.

You said that PANDDA's Standards For Practice are more detailed than the general registered nurse Standards For Practice. Do you think those PANDDA Standards For Practice could be informative, could inform the content of the competency framework?

MS HOWIE: They could be. We did a three-year project around PANDDA Standards so we did some research into it and I wrote about three papers, I think. That was evidence-based so that informed the PANDDA Standards, and they are deliberately different than the Registered Nurse Standards For Practice because we did not want to repeat the Registered Nurse Standards For Practice, nurses should - all practising nurses should be practising according to those Standards, but if they were to practise in the area of intellectual disability and developmental disability, then these PANDDA Standards are much more of a specific guide for

registered nurses practising in that space because at the moment intellectual disability nurses are not recognised in Australia. There is no specialty ---

COMMISSIONER ATKINSON: If I may interrupt. Is it the case that every nurse will deal with intellectual disability in their career because they are found in every part of medical treatment? People with intellectual disability have the same, and perhaps even more co-morbidities than other people but they have the same illnesses as other people, so every nurse is likely to come across someone with an intellectual disability, aren't they?

MS HOWIE: That is correct. This is our concern. People that work in this area is that nurses are not trained in behaviour management or communication, and quite often people with intellectual disability are left until last, and this is what I'm finding in my data analysis and my PhD.

COMMISSIONER ATKINSON: That every nurse needs those skills?

MS HOWIE: Every nurse needs a Registered Nurse Standards For Practice skills, yes. But the PANDDA Standard skills are on top of that, additional skills.

COMMISSIONER ATKINSON: I guess my question was, if every nurse is going to nurse people with intellectual disability, then every nurse needs the capacity, the correct capacity, to properly nurse people with intellectual disability and needs those skills.

MS HOWIE: That is true, yes.

MS WRIGHT: Ms Howie, you have said there is very little content in Bachelor of Nursing degrees in respect of intellectual disability content. Is that right?

MS HOWIE: Yes, there was an audit done by Professor Julian Trollor in 2017 I think it was, and I think half of the bachelor nursing curriculum that did respond to the audit said that 5 per cent of the curriculum contained the intellectual disability content. And I think only one person with an intellectual disability was included in that teaching.

MS WRIGHT: Where do nurses get training in intellectual disability?

MS HOWIE: They don't get specific training in intellectual disability, unless they are in my course or unless there are other champions in Australia that I'm not aware of. Maybe Western Sydney University have some content. Because there is a person there that is the same as me, is another champion. But I do not think they do. They don't get to have placements either in specifically intellectual disability because we have had trouble with that as well.

MS WRIGHT: What about at the post-graduate level? Are there any degrees dealing with intellectual disability?

MS HOWIE: No. So far as I know there are generic ones on disability that a number of universities offer across Australia, but that is for a number of different professions. Registered nurses can do those courses, but they are not specific to intellectual disability.

MS WRIGHT: What would you like to see come out of the Royal Commission?

MS HOWIE: A number of things. I would love to see disability - intellectual disability champions in hospitals, go-to people. That has come out in my PhD data analysis too that people did not have a go-to person like a diabetes educator or an interpreter, or somebody who knew about intellectual disability that could help them, and also in the community, that would liaise between GP practice and the NDIS, and that would help people in the community as well. Like a smoother transition between, or tertiary and primary, secondary care.

MS WRIGHT: And in the area of education and training of nurses, what would you like to see come out of the Royal Commission?

MS HOWIE: Mandatory training for all professions or health professions, not just nursing. I would like to see it mandatory but also in a post-graduate perspective as well, so that people that did work in the community had those qualifications.

MS WRIGHT: Unless there is anything else you would like to add, Ms Howie, those are my questions.

CHAIR: Ms Howie, I will just ask the Commissioners if they have any questions? Commissioner Atkinson?

COMMISSIONER ATKINSON: No further questions, thank you.

COMMISSIONER BENNETT: No, thank you.

CHAIR: Ms Howie, thank you very much for your detailed statement which we have read, and thank you for the ideas that you have expressed both in that statement and today. Thank you very much for your assistance to the Commission.

MS HOWIE: Thank you for inviting me.

THE WITNESS WITHDREW

CHAIR: Yes, Ms Wright.

MS WRIGHT: The next panel will again focus on Propositions 1 and 9, and we will hear from Dr John Bonning of the Australasian College of Emergency Medicine,

A/Professor Leonie Watterson from the Australian and New Zealand College of Anaesthetists, Adjunct Professor Annette Solman, who is the Chief Executive of the Health Education and Training Institute of NSW, and each has already given an oath and affirmation.

DR JOHN BONNING

ASSOCIATE PROFESSOR LEONIE WATTERSON

ADJUNCT PROFESSOR ANNETTE SOLMAN

CHAIR: Thank you Dr Bonning, Professor Watterson and Professor Solman, for coming today to give evidence, we appreciate your attendance, and in the case of Professors Watterson and Solman, for the statements that you have provided to us, I know Dr Bonning is using a statement previously provided at Hearing Number 4, so thank you for those contributions and I shall ask Ms Wright to ask questions of you and conduct the panel.

MS WRIGHT: Commissioners, those statements are at Tabs 8 and 9 of Tender Bundle A Volume 1, and Professor Solman's statement is at Tab 88 of Volume 2. I will just provide some introductory remarks.

Emergency departments often encounter people with intellectual disability and the data shows that people with intellectual disability use significantly more hospital and Emergency Services, including for potentially avoidable conditions. A 2018 data analysis found that people with intellectual disability had 1.6 times the rate of emergency department use, compared to people without intellectual disability, and were more likely to present into the health system via an emergency presentation.

Professor Julian Trollor has commented that this is an indication of poorly-managed primary care needs of that population.

In relation to mental health service use, a data linkage study in 2018 found that after a first-ever admission relating to mental health, people with intellectual disability were three times as likely as people without intellectual disability to present to Emergency departments.

Emergency departments are busy and sometimes confusing environments. It is also a setting where the health professions work together. A single patient can see multiple health professionals over an intense period of time, and as we heard from Dr Palipana yesterday, patients may see a junior health professional without having contact with a more senior doctor who has consulted about their care. This may point to a need for a common set of foundational common knowledge and skills

around caring for people with intellectual and cognitive disabilities among health practitioners in the Emergency department setting.

At public hearing four, Rebecca Kelly gave some evidence about challenges when presenting frequently to Emergency departments with her 8-year-old son Ryan who has Down syndrome and complex health needs. She spoke of a rolling procession of doctors and others attending on Ryan, having to explain and re-explain her son's history, the devaluing of her knowledge and of Ryan himself, the trauma of multiple interventions, misdiagnoses in some cases, and health professionals missing signs of pain.

A doctor herself, Rebecca Kelly considers there are significant gaps in knowledge for most medical professionals in assessing acute care for people with intellectual disability. She notes that this population will often present to hospitals with more advanced and complex situations than would be the case for other patients.

The Australasian College of Emergency Medicine is peak body for emergency medicine and delivers specialist emergency medicine education and training. The College has provided a statement to the Royal Commission outlining its curriculum framework. An issue is what training is specifically provided by that College in the area of intellectual and cognitive disability health, and whether there is scope for enhancing training in this area. We also seek the college's views about the introduction of a competency framework.

The Australian and New Zealand College of Anaesthetists is responsible for post-graduate training programs of anaesthetists and specialist pain medicine physicians, and it is one of the largest medical colleges in Australia, representing over 6,800 trainees and Fellows. Trainees complete at least five years of training.

Anaesthetists work in a broad range of clinical environments from isolated rural eventual to large metropolitan teaching hospitals, and in both private and public practice.

In this context, it is helpful again to draw on Rebecca Kelly's evidence at public hearing four. She spoke of Ryan's need for multiple operations. He had had more than 50 surgeries by the time he was eight. She spoke of a time when - of times when anaesthetists rushed Ryan through the peri-operative stage. She spoke of the time, for example, when she asked for a pre-med three times and each time was reassured that it would be given when Ryan reached the operating theatre, but at theatre the anaesthetist said there was not anything in the notes, and she was not aware that Ryan was not a "typical boy", and instead of stopping and slowing down to discuss his anaesthetic risks and allow time for a pre-med to be administered and to deal with and get to know Ryan, the anaesthetist moved quickly to push him through the process, and Ryan woke up upset and experienced a significant escalation in his anxiety after that event.

We also heard from Corey Burke yesterday who said he experiences anxiety when

undergoing the procedures and was awake during a procedure, and that the anaesthetist did not allow his mentor to be present in the lead-up to the procedure.

In its statement to the Royal Commission, the College of Anaesthetists points out that the Australian Medical Council Accreditation Standards do not specifically mention disability, and this may be an area for advocacy. And further, the word "disability" is mentioned only three times in the College's own training curriculum.

While the College's training program includes learning outcomes that relate to the care of people with cognitive disability, the College considers there is scope to strengthen the emphasis and opportunities to increase the relevance of disability.

We will also hear shortly about the responsibilities and role of HETI, the Health Education and Training Institute in workplace training in NSW.

So if I could start with introductions.

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS WRIGHT: Dr Bonning, your full name is John Bonning?

DR BONNING: Sorry? Yes, John Bonning, President of the Royal Australasian College of Physicians of Emergency Medicine.

MS WRIGHT: You have been a specialist emergency medicine physician for 15 years?

DR BONNING: Correct.

MS WRIGHT: You are giving evidence from New Zealand, is that right?

DR BONNING: That is correct. I have - I did half of my training and have worked annually in Australia since qualifying as a specialist as well.

MS WRIGHT: So you work in both emergency departments in Australia and in New Zealand?

DR BONNING: Primarily in New Zealand, but I have worked - I did two years full-time in Melbourne during my training, and then since then I have worked for about two weeks a year mainly in Alice Springs, but at other locations so I'm familiar with the Australian area, jurisdiction and comfortable with speaking on that.

MS WRIGHT: Thank you. Associate Professor Watterson, your full name is Leonie Watterson?

A/PROFESSOR WATTERSON: That is right.

MS WRIGHT: You are a qualified specialist anaesthetist and Fellow of the College of Anaesthetists?

A/PROFESSOR WATTERSON: Yes.

MS WRIGHT: You are the Chair of the Education Executive Management Committee of the Australia and New Zealand College of Anaesthetists?

A/PROFESSOR WATTERSON: Yes.

MS WRIGHT: And have been a Board member since April this year?

A/PROFESSOR WATTERSON: Since last year, 2019. I have been Chair of the Committee since April this year, during this year.

MS WRIGHT: Ms Solman, your full name is Annette Solman?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: And you are the Chief Executive of the Health Education and Training Institute?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: You are a trained nurse and have over 30 years' experience as a registered nurse?

ADJ PROFESSOR SOLMAN: Over 30 years' experience in the health system.

MS WRIGHT: And how much experience is in clinical practice?

ADJ PROFESSOR SOLMAN: Probably about 20 years, 25 years.

MS WRIGHT: And you are an Adjunct Professor at the University of Sydney?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: And your former roles include Acting Chief Executive of the Sydney Children's Hospital Network?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: Ms Solman, I will start with you. What are HETI's responsibilities in the education and training of health professionals?

ADJ PROFESSOR SOLMAN: HETI has a range of responsibilities in relation to our role, and they are outlined in our determination of functions. So HETI supports the workforce in relation to identifying education and training needs, identified by the State. It also has functions in relation to medical training.

MS WRIGHT: It is the accreditation authority for pre-vocational doctors, is that right?

ADJ PROFESSOR SOLMAN: That is right.

MS WRIGHT: And HETI has standards that it uses to assess hospitals which employ interns, is that right?

ADJ PROFESSOR SOLMAN: It does. They're based on the AMC standards.

MS WRIGHT: Do those standards apply to the first two years of a doctor's training post-university?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: Are there any standards that relate to the healthcare of people with disability?

ADJ PROFESSOR SOLMAN: There is a documented standard, competencies developed by the NSW University funded by NSW Health. They are competency standards.

MS WRIGHT: Do they apply to interns?

ADJ PROFESSOR SOLMAN: No. No, there is nothing in the intern accreditation.

MS WRIGHT: What standards were you referring to?

ADJ PROFESSOR SOLMAN: Sorry, I was referring to competency standards in intellectual disability which I can talk about later. They are not related to HETI.

MS WRIGHT: Just dealing with pre-vocational doctors in their first two years of training. HETI being the accreditation authority for that cohort of doctors, are there standards that deal with the healthcare of people with disability?

ADJ PROFESSOR SOLMAN: No.

MS WRIGHT: Should there be?

ADJ PROFESSOR SOLMAN: I think that is something that the accrediting body should …..

MS WRIGHT: HETI is the accrediting body?

ADJ PROFESSOR SOLMAN: Well, they are based on the AMC standards so we reflect the AMC Standards. So it would require a change of the AMC standards for HETI to make changes to the accreditation standard.

MS WRIGHT: The AMC standards, do they not allow the accreditation authority to set its own standards that apply to hospitals at which interns are trained?

ADJ PROFESSOR SOLMAN: The AMC standards we reflect in our accreditation standards that we use to accredit hospitals, and it is not down to the level of what content should be in programs.

MS WRIGHT: Those standards, Commissioners, are at Tender Bundle B, Volume 2, Tab 65 (audio distorted).

Those standards include --- Ms Solman, they are the pre-vocational education and training accreditation standards, is that right?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: They deal with matters such as governance, management, trainees' work codes and such matters, is that right?

ADJ PROFESSOR SOLMAN: Correct.

MS WRIGHT: And standards are built into the actual training program that pre-vocational doctors receive, is that correct?

ADJ PROFESSOR SOLMAN: Could you repeat the question, there was an echo?

MS WRIGHT: There is a standard that deal with the education and training program that junior doctors receive? Do you agree with that?

ADJ PROFESSOR SOLMAN: There is an education training program requirement, yes.

MS WRIGHT: And that refers to the program being aligned with the AMC's intern outcome statements, the Australian curriculum framework for junior doctors, and any HETI-authorised curriculum in 6.5 of that standard. Are you familiar with that standard?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: That seems to allow HETI to authorise its own curriculum content?

ADJ PROFESSOR SOLMAN: We have not implemented anything in relation to

intellectual disability.

MS WRIGHT: No. I'm just asking if it allows it. Does it allow HETI to authorise its own curriculum content for pre-vocation doctors?

ADJ PROFESSOR SOLMAN: I will have to take that question on notice.

MS WRIGHT: What is your understanding of who sets the content of training for pre-vocational doctors?

ADJ PROFESSOR SOLMAN: My understanding is the training is determined by the local health districts, so that is the hospitals in relation to ongoing training of individuals within that health facility.

MS WRIGHT: Is it determined on a hospital-by-hospital basis?

ADJ PROFESSOR SOLMAN: It would differ from hospital to hospital.

MS WRIGHT: Does HETI have a role in ensuring junior doctors are receiving adequate training post-university?

ADJ PROFESSOR SOLMAN: HETI accredits hospitals for training.

MS WRIGHT: In that role, how do you seek to ensure that doctors are receiving appropriate training?

ADJ PROFESSOR SOLMAN: Through the accreditation process, the training that has occurred in the hospital would be looked at as part of the accreditation.

MS WRIGHT: Intern training is mostly work-placed based supervised training, isn't it, rather than formal didactic training?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: Having finished university, junior doctors are part of the wider training and service delivery environment. Is that right?

ADJ PROFESSOR SOLMAN: Yes.

MS WRIGHT: As well as nurses and other health professionals working in the hospital setting?

ADJ PROFESSOR SOLMAN: Yes, they are part of that broader environment.

MS WRIGHT: In the gap between undergraduate education and specialist college education qualified doctors, what role does HETI play in educating the workforce?

ADJ PROFESSOR SOLMAN: Would you repeat the question? There is a bit of an echo.

MS WRIGHT: In the gap between university level education and specialist college education, what role does HETI play in educating the workforce?

ADJ PROFESSOR SOLMAN: Broadly, if I can talk broadly first, there is a lot of programs that HETI offers that anyone in the health system can engage with, in relation to a whole range of topics, so medical staff can actually access those particular programs.

MS WRIGHT: Could I just stop you there; are they the topics that are in the documents that you have provided to the Commission which are annexed at paragraph 12 of your statement?

ADJ PROFESSOR SOLMAN: I will need to take - paragraph 12.

MS WRIGHT: There is a document at paragraph 12 with 37 modules. Do you recall the 37 modules?

ADJ PROFESSOR SOLMAN: I do recall 37 modules.

MS WRIGHT: When you referred a moment ago to HETI providing a range of courses, are they the 37 modules on cognitive disability that you were referring to?

ADJ PROFESSOR SOLMAN: We do have a range of courses on cognitive disability that were developed in partnership with the NSW University.

MS WRIGHT: When you gave evidence a moment ago that HETI gave the courses, I'm trying to ascertain, are some of those courses the 37 that you identified to the Royal Commission as being relevant to cognitive disability.

ADJ PROFESSOR SOLMAN: I have 23 here that are relevant that I can see.

MS WRIGHT: Do you see paragraph 12 of your statement? That may be the best way to - paragraph 12.

ADJ PROFESSOR SOLMAN: I have paragraph 12, outlining the state-wide education models relating specifically to cognitive disability.

MS WRIGHT: Do you see it says they number 37?

ADJ PROFESSOR SOLMAN: Yes, they do number 37.

MS WRIGHT: When you gave an answer, I asked you about what role does HETI have in educating the workforce between undergraduate level and college education, and you said ---

ADJ PROFESSOR SOLMAN: As I was ---

MS WRIGHT: And you referred to a range of courses. Are these some of the courses, the 37?

ADJ PROFESSOR SOLMAN: Yes, they are some of the courses, that are available.

MS WRIGHT: I see, and they are optional courses?

ADJ PROFESSOR SOLMAN: They are.

MS WRIGHT: Except for one I think on Aboriginal culture, the rest are optional courses?

ADJ PROFESSOR SOLMAN: They are optional courses except ---

MS WRIGHT: Yes, and what is the uptake of those courses? Is it poor, or ---

ADJ PROFESSOR SOLMAN: I will have to take that on notice to provide that data.

CHAIR: Ms Solman, can I ask this question: did you prepare this statement or did someone prepare it for you?

ADJ PROFESSOR SOLMAN: I prepared this statement.

CHAIR: Did you? I see.

MS WRIGHT: I will run out of time, so I will move on.

CHAIR: Yes, please.

MS WRIGHT: Dr Bonning, you would agree that emergency department environments present particular issues for patients with intellectual disability?

DR BONNING: They are challenging for most people who attend, but I would accept that they would be more challenging for those with intellectual disability.

MS WRIGHT: Because of things such as communication issues that patients with intellectual disability experience?

DR BONNING: So yes, look, emergency departments are busy, chaotic, and are challenging for many people who are injured, I obviously accept and understand the statistics given about the higher incidence per population compared to those without intellectual disability presenting to emergency departments, and yes, they would present challenges regarding communication in both directions from the patient to the clinician, and from clinician to the patient.

MS WRIGHT: The patient often has to see multiple doctors starting with a nurse, perhaps, and then moving to a very junior doctor, and recount their history a number of times. Do you agree that that is common?

DR BONNING: It is potentially slightly exaggerated in that yes, you do progress through a system that is generally met by a nurse --- unless you are so critical you come directly into the resuscitation area --- and you would communicate an illness or injury. However, then - and it is not necessarily hierarchical, and certainly there are some hospitals that have only junior doctors but not many, and all hospitals would have --- hospital emergency departments would have systems available where, as there is a hierarchy of support --- if it is junior doctors that you are seeing, say for example overnight when there may not be specialists on, but I would say that --- once you have given you history to the triage nurse, that is then recorded, whether typed or otherwise, and then the next clinician to see you would have that information in front of them and might seek clarity, but I would not necessarily - I do not want to give the impression that one person has to tell the same story five times in succession to successive clinicians, because the system would be that that is recorded and then used by the next clinician. You are next seen usually by a doctor or a nurse practitioner, and they would have that initial information and then use that and seek clarity as they seek to find out what concerns the person presenting.

MS WRIGHT: The College has a curriculum which is taught to any trainee who wants to receive college fellowship?

DR BONNING: Yes.

MS WRIGHT: That training includes both basic level training then an advanced level of training which comprises what you call both early placed and late-placed training, is that right?

DR BONNING: It would. And, with permission, if I could quickly add in that we have non-training doctors, doctors who are not training to be emergency physicians yet, also working in emergency departments who are exposed to the teaching and supervisions of emergency physicians. So we usually do not have post-grad Year 1 doctors, like interns, but sometimes do. And we have PGY2 and 3 doctors, so non-trainees, who are subject to teaching and supervision by emergency specialists as they work in emergency departments. I thought that fact might be useful to the Commission.

MS WRIGHT: Thank you. The College's training, you said, does contain some content, at page 5 of your statement, relating to intellectual disability and cognitive disability. You have said the College has said that is under the heading of health advocacy in the curriculum. Is that right?

DR BONNING: Indeed. In our quality standards, item 1.1 the standard for vulnerable and high-risk patients mentions specifically --- that ensures patients,

regardless of age, ability, have their dignity respected and preserved by systems designed to minimise functional decline, et cetera. So we identify vulnerable populations, that's absolute core emergency medicine.

MS WRIGHT: Okay. So it falls under "vulnerable patient", and the reference in the curriculum is to physical or mental disability. So we take it that is the reference to intellectual or cognitive disability?

DR BONNING: Yes.

MS WRIGHT: But what specific content is there in the college's training program relating to people with --- first with intellectual disability as a subset of people with mental disability or as a subset of vulnerable patients?

DR BONNING: There may not be other than potentially the sort of paragraph I have just given you about identifying vulnerable patients. And if I could also go back just to acknowledge the experience of people such as we have heard the young Down syndrome patients, and the experience of those with lived experience, and I would not wish to dispute or disrespect what they say their feelings are in our system. But yes, generally there would be overall discussion of dealing with all of these vulnerable patients, but would include those with physical and mental disability as absolute core of what we do, but in terms of an explicit framework, as has been mentioned, there may be an opportunity --- across all specialties, I would suggest, be that general practice, anaesthesia, paediatrics, medicine, surgery --- to look at some specific sort of issues relating to people with disabilities. But I would suggest that it is absolutely core medicine in teaching - our teaching involved structured teaching, work-based assessments, and examinations that deal with people such as Down syndrome. That would come up in an exam, Down syndrome patients have a significant incidence of cardiac disease that needs to be looked at as well as intellectual disability, so it is just general across what we do without necessarily having specific points about each person with a specific disability.

MS WRIGHT: There are a whole range of things that are specific to people with intellectual disability, aren't there?

DR BONNING: Yes.

MS WRIGHT: The need to make adjustments to standard practices?

DR BONNING: Most definitely.

MS WRIGHT: Diagnostic overshadowing, unconscious bias --

DR BONNING: Yes.

MS WRIGHT: --- communication skills, recognising signs of pain, all of these things are more challenging with this group of patients, which can all come to the

fore in an emergency department setting. Would you agree with that?

DR BONNING: I would, at the same time as saying that the similar issues come through with cultural differences, people of different religions and indigeneity as well as patients with mental illness such as schizophrenia, and all of these have to be taken into account.

Now, work-based assessments, supervision, teaching and examinations definitely encompass some of these issues across the range of differences in the way that you approach people. Obviously we see patients from the moment of their birth until sometimes over the age of 100, and patients with dementia. Frequently you know you need to involve other parties. You need to look at the background. But again, I acknowledge the chaotic environment in EDs, patients arrive and may not have notes there from previous presentations so we may not know their backgrounds. These are all challenges, but I'm trying to imply that this is core emergency medicine, and taught and examined, and is touched on in our curriculum and quality framework. However, I accept, always accept, it could can be better and would be happy to be part of something that looks at this across the health sector if we wish to develop an explicit framework on this issue.

MS WRIGHT: Because --- I'm not being critical but the Royal Commission asked what proportion of the curriculum is allocated to content concerning intellectual disability or cognitive disability and the College wasn't able to answer that question, question 5, because --- well, I don't know the reason, but it wasn't something the College was able to provide an answer to. Is the reason because it is work-based training and it depends on the particular environments in which the trainees are working? And there is no formal, discrete content on intellectual and cognitive disability in the curriculum?

DR BONNING: No there is no formal discrete, but there is certainly overarching, and again I've mentioned the quality framework item 1.10.1, emergency care for vulnerable patients, it is that sort of overarching approach that we have. No, it is not --- so there is work-based assessments but people train in different areas and different places. There is trainee assessments, there is teaching that occurs both in a centre and obviously virtually. And then there are examinations, which are Australia-wide, in fact they are Australasia-wide, but I will focus on Australia and our examinations cover it all. So it is at a global level, as opposed to an explicit level, I accept what you are saying that we would not have explicit wording about somebody other than --- like the example I gave to you, ensures patients regardless of age or ability, that sort of level.

MS WRIGHT: And the College doesn't engage with people with intellectual disability and cognitive disability in the development of content for its programs and that is so? That is an answer at question --

DR BONNING: Yes.

MS WRIGHT: --- or have staff with expertise or an interest in this area in the College?

DR BONNING: No. We have - so the staff in the College are the administrative, the 110 people who work in Melbourne are administrative staff. And then the teaching is provided by clinicians in hospitals as well as a bit of global teaching provided by .....

(Videolink frozen)

MS WRIGHT: I think we have just had a problem.

DR BONNING: ..... at a state level. And so you would not be thinking of College staff. More our trainers, our specialist directors of emergency medicine training, our specialists that work in emergency departments, they are the ones that you would look to seek expertise in. Again, while there will be overarching expertise it is not explicit. I accept that.

MS WRIGHT: One of the propositions that has been put, and understand you will have had this document, that emergency colleges, including in emergency medicine, should review their curricula to determine what further training is required in this area?

DR BONNING: That is mandated by the AMC.

MS WRIGHT: Well, that is a separate issue. One issue is that colleges should be looking at their curriculum to determine whether their current content is sufficient.

DR BONNING: Yes, I'm accepting that, yes.

MS WRIGHT: It seems that the College may well need to look at its curriculum. Would you agree with that proposition?

DR BONNING: Yes, to look at explicit information about those with cognitive and physical disabilities, I would suggest that that might be a national thing for all specialties from dermatologists, opthalmologists, to GPs, rural hospitals, emergency physicians and otherwise, yes.

MS WRIGHT: Associate Professor Watterson, turning to your college. You have also provided in your statement an overview of some of the learning outcomes that trainees in the anaesthesia training program are required to achieve by the end of the fellowship training. Is that right?

A/PROFESSOR WATTERSON: That is right.

MS WRIGHT: That starts at pages 7 and moves into page 8 of your statement. That includes things like individualising communication and taking into account factors

which include disability and identifying problems that needs to be addressed, including the patient's preferences and cultural beliefs, incorporating them into the peri-operative plan and including patients and their families, et cetera. There is a range of general learning outcomes.

What content in the curriculum relates to those learning outcomes that is relevant to the healthcare of people with cognitive disability? Is there any specific content?

A/PROFESSOR WATTERSON: So, just to clarify the terminology, the curriculum statement has got the learning outcomes. And then we can talk about the content that trainees would utilise to achieve those learning outcomes.

In the curriculum statement that I have provided, you are quite right, there are numerous, in fact, I have easily counted 30 general learning outcomes that are relevant to people with disability in the sense that if they are achieved, people with disability will considerably benefit, I guess. Or everybody will, but I think that is one of the things we're identifying that when they are not achieved, people with disability are disadvantaged.

And in fact, not wanting to digress, I would like to - I have acknowledged your previous witness' statement and would like to apologise for that experience, which I think was unintended but it has happened.

Now when we get to content of the learning outcomes it is a little bit similar to what John has explained. A lot of learning occurs in the workplace and so the content is in fact your encounters with patients in a supervised setting. And then there is private reading. There are some discrete learning activities that are done as online modules or as workshops. But, really, substantially the content is actually the patients you care for. Consequently it comes down to how much exposure a trainee has to people and, in this regard, to people with disability.

MS WRIGHT: Exposure is one thing, but supervisors are also a key, are they not, to the training and education of trainees? And if the supervisors are not sufficiently trained in cognitive disability themselves, there is an issue with the modelling of the behaviour of supervisors? How does the College address that in the area of cognitive disability?

A/PROFESSOR WATTERSON: So, there are some areas in which …. is an example of that ---

MS WRIGHT: We might have just missed something? It froze. There was a technical issue. If you could repeat?

A/PROFESSOR WATTERSON: Sure. Paediatrics is the area in which a trainee would have most exposure to a patient with cognitive disability, not exclusively so. The question of how the college ensures that supervisors are competent, again, that is one of the AMC Standards to ensure that workplace supervisors supervise

appropriately for everything, which includes having content subject expertise.

MS WRIGHT: Could I just take that up. The AMC Specialist Training Standards require the College to employ a range of teaching and learning approaches. It does refer to work-based experiential learning but it also requires the college to use supplementary approaches to learning. That is Standard 4.

A/PROFESSOR WATTERSON: Yes.

MS WRIGHT: Is that a way in which the College could supplement the issue of perhaps supervision not being up to standard, or having its own issues in terms of what is thought in caring for patients with cognitive disability?

A/PROFESSOR WATTERSON: I think there is an opportunity for more awareness knowledge, fluency around the needs of disabled people. And, I guess, that harkens to the proposal number 1. There are some anaesthetists who are more expert than others. Sub-specialist paediatric anaesthetists tend to be highly competent, that is my understanding in this area. Generalist anaesthetists who have less exposure, I would be less confident to say that they are highly competent in this area, if that makes sense?

MS WRIGHT: Well, that reflects some evidence we had yesterday that there is a particular need in the adult sphere. And you have said in your statement that there are periodically viva voce components addressing the needs of the children with cognitive disability which are assessed and examinable and so that trainees coming through do expect it and they do prepare for that. But what about adults with cognitive disability? Is that an area that should be assessed regularly so that trainees know they have to learn about this area.

A/PROFESSOR WATTERSON: As part of my appearance today, I consulted the Chair of the Final Examination Committee where this would be examinable and she confirmed actually that they do examine adults as well as children in their viva voces. But of course the examination committee does not notify trainees about the particular content of exams. And they have eight viva voces, so to cover the breath of the curriculum you are not going to have one in each sitting of the exam. But trainees are very aware there is a reasonable chance that there will be a viva on a child with intellectual disability of some type. Are they wholly aware that they may be an adult? Possibly less so, but I know that is in the raft of vivas that will be presented, and I know from trainees' behaviours that as soon as one appears in an exam, that that will substantially affect their approach to learning, because assessment drives learning.

COMMISSIONER ATKINSON: When was the last time it was included in a viva voce?

A/PROFESSOR WATTERSON: I don't know, and because of the public nature of this hearing I do not actually want to provide too much information on when it might

next appear.

COMMISSIONER ATKINSON: Sure, I understand that. But when you say they are very aware that they are likely to get a viva about a child with an intellectual disability, that you are not really sure that they are also aware that they might get an adult. That rather suggests to me that one might deduce from that that it did not happen recently, but perhaps I'm wrong?

A/PROFESSOR WATTERSON: I would deduce the same. In my dealings with trainees, in their discussions around exam preparation, it is not something that I hear them speaking about.

COMMISSIONER ATKINSON: But they might deuce from this examination if they were aware of it that perhaps they had better prepare for it?

A/PROFESSOR WATTERSON: Correct.

CHAIR: Are anaesthetists given guidance about how to obtain informed consent from someone who may have an intellectual disability for whatever procedure is to be followed?

A/PROFESSOR WATTERSON: It is examined in the workplace as part of formative assessment.

CHAIR: Yes, but in practice when does it happen?

A/PROFESSOR WATTERSON: In practice it happens on an everyday basis where trainee anaesthetists might be observed to be obtaining consent.

CHAIR: Sorry, I did not make myself clear. In practice when does an anaesthetist get the consent of the patient for the administration of anaesthetic for an operation?

A/PROFESSOR WATTERSON: It may happen in a peri-operative out-patient clinic setting, and it may happen in the ward on a day of surgery admission. And periodically it happens in the holding bay of an operating theatre complex.

CHAIR: I asked the question because --- my experience may be atypical, but I have not noticed with anaesthetists in the preoperative consultation for which there is a specific item in the schedule for private health insurance, that it is a really very careful analysis of what is about to happen. And I just wonder how informed the consent would be if somebody had an intellectual disability. I hasten to say my experiences are varied and they may not necessarily be typical.

A/PROFESSOR WATTERSON: Your experiences are valid and it demonstrates that there is some variability. I think one of the other points that you might be getting at in terms of training is to what extent would a trainee be observed in obtaining consent, and they will be on some occasions according to their level of

experience, and once a trainee is considered to be sufficiently experienced in gaining consent, they may do that on their own. And that then, of course, also relates to the complexity of the consent process. So, for example, part of my practice until recently was paediatric neurosurgery, and I would either observe a trainee, or I would also get consent myself from parents --- usually they are very small children --- because of the degree of complexity of that consent process, if that makes sense.

COMMISSIONER ATKINSON: It does to me. I had to give a consent once as a judge to paediatric neurosurgery, so I'm very aware of the complexity of that. But when we are talking about adults it is a bit different because you cannot just rely on parents or caregivers to give consent. It is a question of the informed consent of the adult with intellectual disability, so really quite different from dealing with children.

A/PROFESSOR WATTERSON: That is right. Look, I think probably the knowledge around capacity to give consent and how that is contextual for a person with intellectual disability, I think we could all be a bit better informed and a bit better skilled --- well, not all of us. But I suspect there is some variation in practice as well and in skills, yes. To be perfectly honest, I think that some of these skills are not straightforward to achieve, either. They rely upon not only a commitment to learning, the degree to which one is exposed to certain patients and to some degree the experience and feedback in that process.

MS WRIGHT: Just very briefly, Dr Bonning and Professor Watterson, do we take it from both of you that there is some room for improvement and that you agree with Propositions 9 and 9.1?

A/PROFESSOR WATTERSON: I agree with 1. Although 1.1, 2 and 3 seem straightforward. 1.4 I was wondering a lot about, particularly 1.4(a) and (b), how they might work in practice. Point (d) was straightforward, then 9.1, yes, that seemed quite straightforward. And 9.2 noting that pain medicine is a separate post-graduate program to anaesthesia. That would already, I guess, be a sub-special, like an example of 9.2.

COMMISSIONER ATKINSON: Thank you for that.

Dr Bonning, what are your comments?

DR BONNING: If I could add into the issue that was discussed by my learned colleague about consent. It is a huge issues for us as well. I have consulted my Director of Education and Chief Censor, and we have had in recent exams questions about dealing with elderly demented patients and patients with terminal illness. Of course dementia, whilst not its congenital cognitive impairment, is certainly cognitive impairment, so that is examined in adults, and of course we examine around children as well.

Yes, we do not dispute that we could do better. We all could do better in everything that we do. Looking at Proposition 1, coming up with the competency framework as

I suggested, I believe this is something that could be developed federally across all specialties. I do not believe many specialties would be excluded from needing to know and do better about dealing with patients with cognitive impairment. It is, as we have implied, absolute core to all of our work and dealt with globally. And there are explicit issues that we have touched on, but just yes, focussing on cognitive impairment, sure, it could be better. And the same as mentioning things more specifically in specialist training, Proposition 9, and potentially having modules available for continuing practice development for specialists per Proposition 10.

All sorts of people have difficulty when they meet the health system in any of its different forms and there are always some adverse events and we acknowledge those with lived experience where it has gone less well, but hope that we do train and continually develop a medical workforce that can deal with the entire population, and focussing particularly on vulnerable populations including those with cognitive impairment --

MS WRIGHT: Thank you to all of you for your statements and being here today.

CHAIR: Thank you.

CHAIR: I will inquire whether Commissioner Atkinson and Commissioner Bennett have any questions?

COMMISSIONER ATKINSON: No.

COMMISSIONER BENNETT: No.

CHAIR: Thank you for coming today. We appreciate the assistance you have given to the Royal Commission, thank you.

DR BONNING: --- thank you very much, Commissioners.

THE WITNESSES WITHDREW

MS EASTMAN: If we could adjourn until 2 o'clock?

CHAIR: Yes, we shall adjourn until 2.00 pm.

ADJOURNED **[1.06 PM]**

RESUMED **[2.01 PM]**

CHAIR: Yes, Ms Wright.

MS WRIGHT: We now call (inaudible) is on primary healthcare and post-registration education and training, and we will hear from Dr Brendan Goodger from the Central and Eastern Sydney Primary Health Network, and Dr Larissa Roeske of the College of General Practitioners and Dr Sarah Chalmers of the Australian College of Rural and Remote Medicine.

At Public Hearing 4 the Royal Commission heard that primary healthcare is of critical importance across the lifespan of people with intellectual and developmental disabilities, and that preventative healthcare measures among populations with disability are generally very important. Studies have shown that people with intellectual disability have significantly higher numbers of unmet needs and low uptake of preventative health services compared to the general population.

General practitioners and other primary health professionals are of course the gateway to basic health prevention measures such as screening measures and comprehensive annual health examinations.

The College of General Practitioners is Australia's largest professional general practice organisation and has over 40,000 members. The College offers training pathways leading to specialist general practice qualifications as general practitioners. A particular feature of this College's training is that it is delivered by regional training organisations. The College of Rural and Remote Medicine provides a fellowship program for doctors wishing to specialise in rural general practice. Both Colleges have provided statements to the Royal Commission outlining the areas where their curricula on training have relevance to people with cognitive disability.

The Central and Eastern Sydney Primary Health Network is the second largest primary health network Australia, and covers a region stretching from Strathfield to Sutherland and includes Lord Howe Island and Norfolk Island.

13,000 people with cognitive disability live in the Central and Eastern Sydney PHN region with a high proportion being children. 24 per cent of Aboriginal young people living in its region have been diagnosed with cognitive disability. The PHN Statement states that people with cognitive disability are a priority population as they have poorer health relative to the general population and higher health an social care needs.

Central and Eastern Sydney Primary Health Network has undertaken initiatives to develop and deliver training opportunity for GPs, allied health professionals and community organisations in the area of intellectual disability health. It was one of the four PHNs funded to lead the development of the Commonwealth Primary Care

Enhancement Program which is a key short-term element of the draft national roadmap on the health of Australians with intellectual disability.

The Primary Care Enhancement Program aims to enable better models of care for people with intellectual disability. The council for intellectual disability was funded to lead the development of national resources for the PCEP over a two-year period from 2020 to 2021, and we will hear now, Commissioners, some evidence from Laura Naing, who is employed by the Council for Intellectual Disability to assist in the development of those resources before we turn to hear evidence from the three panel participants.

CHAIR: Yes.

MS WRIGHT: If that could be played.

[VIDEO RECORDING PLAYED]

MS BROOKS: My name is Hayley Brooks, and I'm a manager in the inclusion project team at the Council for Intellectual Disability, and I am managing a project which is part of the Primary Care Enhancement Program where we are working with PHNs to improve healthcare for people with intellectual disability, but Laura will talk more about that project. Laura, would you like to talk about yourself?

MS NAING: Yes. I am Laura. I have intellectual disability. I'm very proud to be doing this PHN project. Educating and making awareness for a better health system. I want to help people from the towns, communities and rural regions to access health services.

MS BROOKS: That is great, thank you, Laura. Would you like to talk about your job here at CID?

MS NAING: Yes. I most assuredly would. I'm an Inclusion Project Worker at CID. I will be educating and making awareness for people from CALD backgrounds to access these services and to promote training and resources. People with disabilities, like me, not to be afraid to speak to doctors.

MS BROOKS: Yes, and we have spoken about it is really important that people don't feel afraid to talk to their doctor.

MS NAING: Very important.

MS BROOKS: Can you talk about the project that we are doing?

MS NAING: What we will do in the project. We will do the training for doctors and health people. We will deliver resources for doctors and health people how to access

the National Disability Insurance Scheme, people with intellectual disability in Easy Read. People we will work with. We will work with four Primary Health Networks in Central and Eastern Sydney, NSW, Western Victoria, Sunshine Coast, Queensland, Tasmania.

Primary Health Networks improve medical service for everyone. We will also work with health people and people with intellectual disability who are interested in making healthcare better for people with intellectual disability.

MS BROOKS: That is great. Thank you, Laura. Can you talk about some of the things you are doing on the project?

MS NAING: I am doing - what am I doing? I am attending meetings to learn what people do not know, no about health. I met with Multicultural Health last week. I will help the project team to make resources Easy Read.

MS BROOKS: And you are a great person on our team, and we are very grateful to have you working with us. Can you talk about the training and the resources that we are going to be creating?

MS NAING: It will focus on communication, it will focus on attitudes, it will focus on treatment. When it comes for treatment or elective operation, people with disability should not have to wait on a waiting list because our health could deteriorate.

MS BROOKS: Yes, and we have spoken about how people sometimes get denied the treatment, as well as having to wait.

MS NAING: And it's not actually, not a good idea, because it's important to go straight away. Get it done!

MS BROOKS: Yes.

MS NAING: Without waiting.

MS BROOKS: Thank you, Laura. Why do you want to help with the project, Laura?

MS NAING: People with disability don't get to live a longer life. We want to live a longer life with other people in our society. I know how a doctor treats me, and so I want to help to train and educate them to help others.

MS BROOKS: That's great. Thank you, Laura. And what do you think are some of the things doctors should now about helping people with intellectual disability?

MS NAING: Doctors need to explain information to me and explain again if a person does not understand. This is, for example, the doctor told me I need a biopsy

done. I did not understand what it was. Being more aware of what disability, not just assume, I'm okay. Don't use medical terminology when you are speaking. It is very hard to understand. Speak slowly.

[VIDEO RECORDING ENDED]

MS WRIGHT: I'll leave that there.

DR BRENDAN GOODGER, PREVIOUSLY SWORN

DR LARISSA ROESKE, PREVOUSLY SWORN

DR SARAH CHALMERS, PREVIOUSLY SWORN

EXAMINATION-IN-CHIEF BY MS WRIGHT

MS WRIGHT: Dr Brendan Goodger, you are the General Manager of primary care improvement at the Central and Eastern Sydney Primary Health Network?

I think you might need to unmute.

DR GOODGER: Yes, that is correct.

MS WRIGHT: And you have over 20 years' experience working in health?

DR GOODGER: Yes, that is correct.

MS WRIGHT: You have worked in health planning and health planning for both the Commonwealth and NSW Governments, particularly in the area of priority population groups. Is that right?

DR GOODGER: That is right.

MS WRIGHT: You are a trained clinical social worker?

DR GOODGER: Yes, trained clinical social worker, with a PhD in Clinical Epidemiology and Community Medicine.

MS WRIGHT: Thank you.

Dr Larissa Roeske your full name is Larissa Roeske, have I pronounced that correctly?

DR ROESKE: Yes, that is correct.

MS WRIGHT: You are the Chair of Royal Australian College of General Practitioners, specific interest group, disability, is that right?

DR ROESKE: Yes, the specific interest faculty, and within that is the specific interest disability group.

MS WRIGHT: I see, and you form part of the disability group, is that right?

DR ROESKE: Yes, I do. Yes. I'm a member of that group and I chair the group.

MS WRIGHT: Thank you. You have over 20 years' experience as a general practitioner?

DR ROESKE: Yes, I'm a previous practice owner and general practitioner with 20 years' experience in clinical general practice.

MS WRIGHT: Dr Sarah Chalmers, you do not work for but you represent the Australian College of Rural and Remote Medicine?

DR CHALMERS: That is correct. I'm the current President of the College.

MS WRIGHT: And you have worked in private general practice, hospitals, and remote Aboriginal communities and homelands in the Northern Territory? Is that right?

DR CHALMERS: That is correct. I'm a rural generalist. So I am a GP. So rural generalists are general practitioners. We are people who specialise working in rural and remote areas, so have extended skills in remote rural and remote practice, which can include working in hospitals. So I'm currently working as a rural generalist in Wyndham in Queensland.

MS WRIGHT: And before that did you work in East Arnhem Land for about 15 years?

DR CHALMERS: That is correct.

MS WRIGHT: As a GP?

DR CHALMERS: As a rural generalist.

MS WRIGHT: You have also taught medical students at Flinders University in the Northern Territory?

DR CHALMERS: That is correct, and I also currently work at James Cook University so I know longer work at Flinders University but I have moved over to James Cook University so I and involved in teaching medical students and GP registrars.

MS WRIGHT: You have a particular interest in remote practice and Aboriginal and Torres Strait Islander health?

DR CHALMERS: Yes.

MS WRIGHT: Dr Goodger, the Central and Eastern Sydney Primary Health Network seems to have several different streams of work that are relevant to the training of general practitioners and other allied health professionals. I wonder if you could provide an overview of the main areas of work that are aimed at the training and upskilling of primary health professionals.

DR GOODGER: Yes, thank you for that. First of all, we run a very detailed and comprehensive CPD program. Over the last year we have run 20 CPD events with the NSW Council For Intellectual Disability, but also with the local specialist disability support teams, so 20 events that have reached nearly 700 people.

About 20 per cent of those have been GPs, 40 per cent are allied health, and the remainder have been community-based members. So it is a very active CPD program. In addition to that we also provide support to practices around trying to encourage the uptake of health assessments, and also with some of their digital enabling technologies. Importantly for us, what we have done is we have also established a disability support network that every quarter has 260 people meet, 260 members that meets every quarter. It is a very active group. What we have also done, too, is we are also offering training to all staff in disability awareness, and by certainly in the first quarter of next year all our staff will have completed that disability awareness training. We hope to roll that out further. Of course we are also participating as part of the PCEP and undertaking a range of research capacity building projects as well.

MS WRIGHT: I will come to the PCEP in a moment, with the network you referred to, is that called a disability network?

DR GOODGER: Yes.

MS WRIGHT: And 260 members, what is the make-up of the members? Are they GPs?

DR GOODGER: Yes, we have some GPs. It is chaired by a GP, the co-chair is someone with a lived experience of disability, and the range of topic areas is from NDIA. We have had presentations from GPs, we have had presentations from our specialists discipline support teams, we have had presentations on the use of the

health record, those kinds of things, to try to promote more integrated care, the impact of more integrated care amongst the disability network.

MS WRIGHT: The PCEP is a particularity important stream of work, is that right?

DR GOODGER: That is correct.

MS WRIGHT: Has that commenced yet or are you still in the planning stages?

DR GOODGER: We have now developed a service model and putting it out for consultation. That will be finalised by the end of January, and we hope to have the recruitment of the positions hopefully out before Christmas. Hopefully they will be --- those staff members will also be on board in, I would say, mid or late February.

The other thing I want to do is appoint a GP medical advisor as well, to provide some assistance to me on this, and we think that is really, really important to try to encourage, to try to encourage greater clinical care and support for those GPs interested in participating in taking up issues around social disability.

MS WRIGHT: What will be the first step next year once you have done that recruitment the planning stage?

DR GOODGER: Yes, the first improvement is around --- one of the issues that has been identified for us is GPs struggle to help navigate the system because the system is incredibly complex. What we will be doing is employing some service navigators who go out and visit our 609 general practices in our region. They will work in with our practice support team, of whom we have eight FTEs, but these navigators will go out, and they will work for the practice managers, they will work for the practice nurses, they will work for the GPs, to try to enable them to provide better support when they are trying to look at where their patients should best get care.

Often what happens is when a GP sees someone with a intellectual disability, it is like they do not see them very often, it's like, where should they go, what is the best care, what services are around there? What this navigator will do will help do that. In addition, if I may, we will also employ than a educator, and we think this is absolutely crucial because part of it is around building up the knowledge of local general practitioners but also allied health. We have nearly 12,500 allied health providers in our region, so we also want to build up and extend that primary care workforce, and to have these navigators concentrating on that primary care workforce, those GP, those allied health.

MS WRIGHT: What will be the role of the educators and how many will there be, do you expect?

DR GOODGER: Initially there will be one, but we hope to have one on that. So one, up to two, but again they will work with the navigators, they will and also run our CPD program or be involved in developing events. If we can, I would like to

establish a community practice or something like that to really encourage those GPs who are interested to get together, because at the moment GPs who are interested in intellectual disability feel quite isolated. That is certainly what we have heard. In our region, they are practising in quite an isolated way, despite their best intentions. They want to work with others, it is just that they are isolated. We want to try to bring them together and really try and harness that, because providing care for someone with a intellectual disability is incredibly complex, given the current funding and system arrangements. So what we hope to do is provide some education, for example, how to do case conferencing, how should multi-disciplinary team work look, we have telehealth, we have other practice support systems that are being developed, so how do we best utilise that to get that multi-disciplinary teamwork happening?

That is why we want someone to actually go out to the practices to do that practice education.

CHAIR: Dr Goodger, I wonder if you could speak a little more slowly because we need to interpret, our Auslan interpreters need to interpret your evidence and we have a real-time transcript so just a little slower would be good.

DR GOODGER: Yes, thank you.

MS WRIGHT: Dr Goodger, you spoke about the importance of GP its and allied health professionals building networks where they can share their knowledge and resources. Are there any resources that you will be providing as part of the PCEP?

DR GOODGER: Yes, there will. We have already developed quite a large range of resources ourselves through our ongoing education program, but what we will also do is work very closely in with the Council for Intellectual Disability. We think that it is absolutely fundamental, there is quite a lot of resources out there now, so it is about pulling together and making sure that they are localised, that they are relevant to our practitioners and our region.

MS WRIGHT: And how are they to be made accessible to general practices?

DR GOODGER: So what we will do is again we will run a large lot of events. We will also visit those general practices, and actually do some one-on-one education sessions with the practice managers, with the practice nurses and the GPs. So it really is that one-on-one type work.

But in addition to that, it is also about holding workshops where we can bring those who are interested and really try to foster that sense of collaboration and sense of community around education, and hopefully also to develop up a sense of - a commitment to quality improvement around intellectual disability, because that is one of the other things that we have identified as being a really crucial issue, which is around how to have a continually improved services - how to continually improve the services.

MS WRIGHT: Dr Roeske, does the College of General Practitioners have any role in building networks between fellows of the College once they have completed their education and they have their formal fellowship qualifications, and may have an interest in intellectual disability?

DR ROESKE: Thank you. Thank you for the question. The answer is yes to both. I should also mention that I'm a Director of the Board of the College, and I feel that it is important to mention that I am a parent and a career of a son with a severe cognitive disability.

To go back to your question, the College, through its faculty of specific interests, has a current network of 752 GPs nationally, so across States and Territories, that have voluntarily joined the group which is currently overseen by Associate Professor Robert Davis. The purposes of this network are to advance the skills and expertise of GPs that are working and providing healthcare to patients with cognitive disability and other disabilities. Also to advocate on behalf of patients, to represent patients and primary care in this area, so representative role. Also, a role in collegiality and a role in research. Currently this group is in the process of developing a recognition framework to actually define what advanced skills are in the GP context, in the provision of healthcare, to people living with disability including those with cognitive disability. The group is also advising the Board around position statement that would be considered, so that is being prepared by the college.

And the Group has been active to date. Its representatives include academic GPs, researcher GPs, GPs who have led three Centres of Excellence in developmental disability, GPs with lived experiences of living with disability themselves or caring for close members with disability.

The group also caters to early career GPs and is inclusive of registrars and trainees that may be interested in both mentorship and learning.

So it is actually probably quite an important group in terms of its ability to inform the membership broadly, which is actually in excess of 43,000 currently, and also provide advice to the Board and consideration through the appropriate committees.

MS WRIGHT: Did you say 752 GPs have an interest in the provision of care to patients with intellectual disability?

DR ROESKE: Yes, who have voluntarily joined this specific interest group, yes.

MS WRIGHT: You referred to the College's work in identifying advanced skills in this area?

DR ROESKE: Yes.

MS WRIGHT: Would there be a form of recognition for that, or is that more in the

nature of a competency framework that has been provided?

DR ROESKE: Thank you for that question, because there is a level of competency that is attained at the fellowship level, but there is also an understanding and appreciation that it can take many years to develop additional or advanced expertise beyond that of competency that would be considered for the provision of healthcare to people living with disability. This, would is still in its early stages, but has been identified as an important process, so at the moment that work is being resourced by the College and will be led by this group within the faculty of specific interests. It is a recognition process at the moment, that might actually then inform what a forward-facing pathway might look like.

MS WRIGHT: Both colleges, the College of Rural and Remote Medicine and the College of General Practitioners, deal with general practice. Is there - do you do any work together in this space or is there any overlapping of work in the area of intellectual disability?

DR ROESKE: Look, I'm not aware of overlap, I'm not sure if Sarah is. So I guess - no, I'm not aware of any area of overlap other than there may be some potential for that but not aware of it.

DR CHALMERS: I would agree with that. I'm not aware of any formal overlap in the area.

MS WRIGHT: Dr Chalmers, those who specialise in rural and remote medicine, they come out with a rural generalist specialty, is that right? Generalist practice specialty?

DR CHALMERS: Yes. So we are - our --- through AMC the recognition is as general practitioners, and so rural generalist is an internationally recognised - excuse me. So it is internationally recognised as a position, but as I said, through the AMC it is recognised under general practice.

MS WRIGHT: Trainees and fellows there are then working in private general practice generally? Is that right, as opposed to ---

DR CHALMERS: No, not necessarily. So they can work in private general practices. In --- the more remote you go, the more difficult it is to manage a private general practice, and certainly when you are working out in very remote areas and particularly in remote Aboriginal communities, they will often employ through community-controlled Aboriginal organisations. So - and people often actually are employed in multiple --- by multiple employers, so they may do private practice during the day, work in an Aboriginal-controlled medical service on some days, and may also be employed by the hospital, so work across a wide range of services.

MS WRIGHT: If I could draw on your experience in that context of dealing with patients in the Indigenous context, the evidence shows that intellectual disability is

more prevalent in the Australian Indigenous population compared to the non-Indigenous.

What observations have you made in that context over your many years of medical practice in First Nations context? Do you have anything that you can share in terms of your observations of the adequacy of training provided to doctors in caring for Aboriginal and Torres Strait Islander People with cognitive disability?

DR CHALMERS: The way that this is managed in general practice training is we - so GPs are trained in generalism, that is what we do. And we are required to be able to manage pretty much anything that a patient presents with.

I think it is a very important part of how this is managed, is we talk about patient-centred care, and have a particular focus on doctor-patient relationships, and so in a general sense, what this means is that anybody who walks in the door, a GP is trained to form a relationship with the person and hopefully over a long period of time, because we work across - we talk about continuity of care as well. In particular for the Aboriginal communities that I have worked in, this is really the general approach, which is that a person comes to see you or is brought to see you by their carer, and your job is to focus on the patient to build rapport and to manage the issues that they present you with. So I don't know if that answers your question.

MS WRIGHT: It does, in part. One of the things the Commission is interested in in this hearing is whether a competency framework is needed, which identifies the skills and attributes and knowledge that health professionals should be taught in intellectual --- the Commission uses the expression "cognitive disability" as an umbrella term.

So I was asking whether you have any observations on whether those attributes and skills are common to all people with cognitive disability or whether there is any particular or specific training needs for health professionals when dealing with First Nations people in this group.

DR CHALMERS: So yes, I guess what I was trying to say before is that we train everybody to be able to manage the person that presents in front of them and the issues that they present with. In terms of specific competencies and frameworks, certainly you could --- I think if you tried to put together competency and framework for every single possibility of a condition that a person could present with, that would obviously be very difficult to teach, very difficult to assess. So I think we try to ensure that our practitioners are able to deal with the person that is sitting in front of them, and to know how to get more information if they feel that they don't actually have the skills for the person who is in front of them at the time.

MS WRIGHT: One of the areas you noted in your statement where the curriculum does deal with disability is in communication skills. Is that right? And the curriculum deals with good communication, the impact of cultural and linguistic differences on effective communication. It does seem to be at a quite high and

general level. Is there anything specific in the training on dealing with people with cognitive disability?

DR CHALMERS: There are a number of - I'm trying to think of the correct term, through the curriculum there are a number of statements as to what a rural generalist should be competent at, at the point of fellowship. They are probably not as specific, specifically referring to cognitive disability, but they go across a range of different disciplines, so including mental health, aged care, paediatrics, so there are a number of competencies through the curriculum that relate to the diagnosis of cognitive disability and management of people that are identified, or who present with a cognitive disability.

MS WRIGHT: The doctors who go through your College's training would be expected to be seeing a higher proportion of Aboriginal and Torres Strait Islander patients, wouldn't they? A higher proportion than, say, the College of General Practitioners, by virtue of the location of the work?

DR CHALMERS: My understanding is that there are more Aboriginal and Torres Strait Islander People living in metropolitan areas rather than rural and remote areas, but you might be referring to is people who work specifically in remote communities, and yes, absolutely, being able to - we actually also, as well as having competencies around managing or dealing with patients of Aboriginal and Torres Strait Islander descent, we also have one of our advanced skills specifically relating to that, so yes, it is definitely part of our core curriculum as well as advanced specialty training.

MS WRIGHT: Given the high prevalence of intellectual disability in that population, do you think there should be greater emphasis on cognitive disability health in the curriculum or do you think it is sufficient?

DR CHALMERS: I think that at this point in time the curriculum manages - it does deal with how to manage somebody with a cognitive disability. We also - there are also a number of - you know, the College offers a number of extra - sorry, trying to think of the word - CPD activity that relate to specifically managing somebody with a cognitive disability. I think it is also worth saying that again in rural and remote communities, our resourcing is much less than it is in major metropolitan areas, and to back up some of the things that Brendan was referring to earlier, we very much work in multi-disciplinary areas, and so in some cases it may be that perhaps the doctor is not the specialist in that area but will have other allied health professionals around them that will help guide them in their care.

MS WRIGHT: But you have said in the statement that the College could include more training on communication competencies and its courses to include cognitive disability resources and references to the skills and competencies needed.

DR CHALMERS: Yes.

MS WRIGHT: Do you agree with the propositions that the Royal Commission has prepared, such as Proposition 1, which is to create a competency framework? Do you have any comment to make about to be Propositions?

DR CHALMERS: Yes. Yes, absolutely. As I said, there are some processes through - some point in our curriculum that refer to that, but as I said, it seemed to be a bit more scattered through aged care, mental health, as opposed to being specific for people with cognitive disability, and I think having a framework to put --- to base - whether it was additions to the curriculum or extra CPD-type modules for practitioners to use, definitely.

MS WRIGHT: So, could allow you to assess where the curriculum is adequate at the moment?

DR CHALMERS: Yes.

MS WRIGHT: Dr Roeske, do you have any comment on the Propositions and the utility of a competency framework for assessing the College's existing curriculum on cognitive disability health?

DR ROESKE: I think we would welcome a generalised guidance, and I think a competency framework that really speaks to primary care in its fullest sense. So we recognise the GPs are critical, but the other providers that are also very important. So we feel that while we do provide for, and we provide resourcing and guidance and standards around the provision of healthcare to people with cognitive disability, that that again could be further developed and enhanced. And so there is work to do there, and I think the College would welcome broadly an overarching framework that sets a certain standard for all those actually, in the primary care setting to be guided by. I think it is very important though that we are able to develop and set standards that are informed by the general practice perspective, and by that I mean the diversity of general practice, which isn't just private general practice but is community health, we have many GPs working in Aboriginal health controlled services, in metropolitan, regional, rural and remote Australia, and in a range of other settings.

I also should note that there are many general practices that are owned by corporates, and again, they will often be developing their own education and training programs and may look to the various colleges, both colleges, I guess, for standards and for accreditation of those activities.

MS WRIGHT: In terms of becoming a qualified general practitioner, there are a number of pathways, aren't there? One is the Australian General Practice Training Program, and then there is also the Practice Experience Program?

DR ROESKE: Yes.

MS WRIGHT: The training under the Australian General Practice Training Program is delivered by a regional training organisation, is that right?

DR ROESKE: Yes, that is correct.

MS WRIGHT: The College sets the curriculum, but to what extent do the regional training providers establish their own curricula? Does it have to be consistent with the College's curriculum?

DR ROESKE: Yes. I don't think you would say that they establish their own curriculum. They would need to follow a set curriculum, and within that they would have the flexibility about what --- you know, how material might be presented, in what format, and that there would be flexibility around the timing in which trainees were exposed to education and learning opportunities.

I think you bring up a very important point, which a lot of this learning occurs in the practice setting where it must happen, and that a curriculum is really a set of standards and guides, but the learning needs to be applied and practised, observation is incredibly important. I note that in the Propositions there is mention of supervised clinical attachment, and this is very much the philosophy that underpins the way that we learn when we are training. It is important that supervised clinical attachments allow exposure to trainees to the delivery of healthcare in the settings that they are actually training, so it is important to understand that cognitive disability and provision of healthcare to those living with cognitive disability is part of the experience of a trainee, and certainly we do set out in our curricula and expectations that that would be met.

We also have a process that monitors that, and a process around remediation should a standard not be met, so monitoring and evaluation is also important.

CHAIR: Dr Roeske, I wonder if you could just help me make sure I understand how the system works. What is the earliest that I, having graduated from a medical school, can hang out my shingle to be a general practitioner? When can I do that?

DR ROESKE: Usually after you have graduated from medical school, you may spend one or two years in the hospital system. You are an intern basically then a first-year graduate in a hospital system. Somewhere around that time, doctors make a decision about whether they want to pursue a career in general practice. It may occur later. But the majority would, around that time. And around that time they would join a training program, either with the RACGP or with ACRRM and ---

CHAIR: Just pausing there, do they have to join the training program?

DR ROESKE: Yes.

CHAIR: Why is that?

DR ROESKE: Okay. Because the training program provides training that is specific and unique to the specialty of general practice which cannot be gained purely in a

hospital setting.

CHAIR: You do not however need, do you, the attainment of FRACGP to practice as a general practitioner?

DR ROESKE: You would need a FRACGP to be a Fellow of the Australian College.

CHAIR: I understand that. But my question is, do you need that in order to practise as a GP?

DR ROESKE: I guess the other qualification would be the one that is offered by ACRRM. I guess --- so I have heard from Sarah that GPs that graduate from ACRRM are rural generalists, so I'm not sure how we reconcile that.

DR ROESKE: They are GPs. If you have a FACRRM or an FRACGP, you are recognised as a specialist in general practice.

CHAIR: Yes, but maybe I'm missing something here --- it is quite a common phenomenon --- but I'm just trying to ascertain what someone who wishes to be a general practitioner must do. I understand that you can get specialist accreditation and you can become a fellow and so on. But what is actually necessary as the minimum requirement to practise as a general practitioner?

DR ROESKE: Look, my understanding, to be approved with AHPRA and to access the Medicare item numbers, you would need to complete a minimum with our College of - through four years and sit and pass the fellowship exams and be awarded a fellowship, so I can speak to that accurately.

CHAIR: You said at paragraph 12 the College has 40,000 members.

DR ROESKE: Yes.

CHAIR: All of those, have they attained FRACGP or are they all seeking to attain it? What is the proportion?

DR ROESKE: Thank you for that question. It is, as of this year's annual report, it is 43,000 for the record or just over. We do have - my apologies that I cannot tell you the exact year but we have a large proportion of senior GPs who practised as GPs prior to, I guess --- the onset, if you would like, of the defined training pathway to be awarded a fellowship, and so they may be recognised through a process of recognising previous or experience and would have gone through a process to be recognised in that way. So I guess ---

CHAIR: That is the grandfather or grandmother clause. We have that, yes.

DR ROESKE: That's correct, yes.

CHAIR: And the rest?

DR ROESKE: I mean, to a great degree I think that probably represents the membership. I'm just thinking if I'm missing a category and my apologies if I am. I'm happy to try to provide that information to you more accurately. But I think that would represent the two, by far, largest cohorts of our members. We do have retired members and members who are on leave from clinical practice, but yes.

MS WRIGHT: You set out from paragraph 127 or 128 the core skills to work in general practice, and the five domains that are covered, which includes communication skills and other domains.

Then, Dr Roeske, you have said there are also some contextual units that are particularly relevant to people with disabilities. And there are two such units. Is that right?

DR ROESKE: Yes.

MS WRIGHT: What is the relevance of those units? Are they learning outcome or are they taught content? Or assessed content?

DR ROESKE: I'm just going to look at the document myself.

MS WRIGHT: That is at paragraph 130.

DR ROESKE: Yes. Yes, so with the two, the second one refers to the residential care context unit. So it would refer to the provision of healthcare to individuals who are residing in residential aged-care facilities that have cognitive disability. Now, a proportion of those will be there because they have acquired this disability later in life, so they may well be aged-care residents, but we also know and provide care to a large proportion of residents that are not aged or aren't elderly, but in fact are in these facilities because there is no other suitable accommodation for them.

And it would talk about the provisions ---

MS WRIGHT: I'm just asking how are these taught? Is this subject matter taught as part of the curriculum? Do they have to be taught as part of the regional training?

DR ROESKE: They would be taught actually in clinical regional practices, so the regional training providers oversee hundreds of clinical practice settings that have identified GP supervisors and GP educators that take trainees --- are accredited to take trainees, and provide them with that experiential learning through a period of years at basic level and then at an advanced level, so that is Year 1, Year 2, then at a more advanced level, and with the progress through, these GP trainees would, for example, attend residential aged care facilities or group homes or other settings that are being visited, so they would basically function and emulate what the GP

supervisor educators were doing in the practice, but at a level that was appropriate to their level of training and also being supervised.

MS WRIGHT: How do you monitor the learning outcomes for people with disabilities are properly taught in that supervision model?

DR ROESKE: You mentioned learning outcomes. There would be --- the trainee would be required to provide a case report or a case report analysis, discussion with their supervisor. There would be external visits made by external supervisors to meet with and assess both the exposure, the experience, the learning, and the understanding demonstrated by the trainee. And that would be provided back in a report. And that would be assessed as whether it was meeting competency standard or not, and if it wasn't, there would be an attempt to provide that experience.

That works not just for cognitive disability healthcare provision, but across the whole range of health issues and problems that are managed commonly in the general practice or primary care setting.

MS WRIGHT: For both of the colleges ACRRM and RACGP, do you both assess in the final examinations for cognitive disability health on a regular basis?

DR ROESKE: Sarah, I will go first, if that is okay. The group that I referred to at the start submits and regularly submits exam questions and scenarios around a range of issues, including cognitive disability, as would other members in the College. Those would be vetted and assessed and developed, and then incorporated usually overseen by the Director of Education and her team, currently it is a her - for inclusion in the exams. I can't say to which - to the frequency with each exam cycle and we can run four or more each year, but there is a process in place and I understand that questions in cases are regularly submitted for those exams.

MS WRIGHT: Dr Chalmers, what about your college?

DR CHALMERS: So there are a couple of different exam formats, so there is written examinations and as well as what is called Primary Care Standards, which is a combination of an OSCE and a viva. I am unable to actually get evidence as to how many of our multi-choice exam questions directly relate to cognitive disability. However, I was - STAMPS, so it is an exam that is run twice a year, has about between 10 and 12 stations at each exam, and there is at least one question each year that relates specifically to the case of including a cognitive disability.

MS WRIGHT: Dr Goodger, you also mentioned that the PHN is doing work to its standards, continuing professional development programs to provide further training opportunities in cognitive disability for medical and allied health professions. There has been some evidence received by the Commission that where CPDs are offered and they are optional in this area, there is fairly poor uptake by general practitioners who might regard this as a very small subset of their patient population. How do you reach those more reluctant GPs with your CPD program?

DR GOODGER: Thank you for that. What we have been doing is utilising our disability support network to really try to grow our reach, but also in our general areas of CPD, what we are doing is putting a specific reference into those people with an intellectual disability or a cognitive disability, so in other words we might be discussing a health condition and what we will do now is we then reference to intellectual disability. So that way we are trying to reach a broader group of general practitioners.

The other thing that we are doing is getting - we have about four or five GPs in our region who are well known and who are really strong, passionate advocates; we also get them to present in those events and we are also leveraging off our specialists in our disability support teams in both Local Health Districts to also encourage GPs to attend as well.

MS WRIGHT: What would you like to see in place in five years from now, if you had a wishlist, in terms of improving health care to people with cognitive disability?

DR GOODGER: Thank you, I will try to be brief. We would like - we believe that there could be a greater emphasis on some of the accreditation standards, and we think that they could be - the issue of cognitive disability could be reinforced in the accreditation standards. It is mentioned ---

MS WRIGHT: Sorry, applying to which level of education?

DR GOODGER: I'm referring to accreditation for general practice. So, for example, it's about trying to upskill general practice staff in their attitudes and approaches to those with a cognitive disability. So that would be one strategy to build that more strongly into the accreditation processes for general practice as a way of upskilling staff and making sure that they have the appropriate systems in place to support that.

The other thing we have made a recommendation in our submission is around creating centres for GPs to participate both in terms of a multi-disciplinary care planning --- because at the moment GPs are not really well-incentivised for that, but also something like a practice incentive payment that directly targets cognitive disability. At the moment we have practice incentive payments for a range of different areas, but there is none specifically for cognitive disability, and so what that means is that it is around the incentive, it is around a commitment to quality improvement.

Practices who participate as part of the practice incentive payment have to make a commitment to ongoing quality improvement that is then backed up by tailored support by the primary healthcare networks such as ours.

MS WRIGHT: So general practices at the moment can't get a practice incentive payment for cognitive disability?

DR GOODGER: That is my understanding, yes.

MS WRIGHT: And that is a matter for the Federal Government, is it? Who administers the practice incentive payments?

DR GOODGER: That is correct. Sorry.

MS WRIGHT: Who administers the practice incentive payment?

DR GOODGER: Yes, correct. And they were released last year, a range of definitions were released last year, and I have no doubt that that is under development, but at the moment there is not a present incentive payment for cognitive disability, that is my understanding.

MS WRIGHT: What would those payments enable?

DR GOODGER: They would enable practices to be much more involved in terms of quality improvement. So for example, to be able to undertake some audits of the care that they provide, to be able to get more involved in terms of that sense of --- the ability to have more multi-disciplinary team-type work. That is the design --- and also indicators for how they are managing people with a cognitive disability. That is what we are trying to do for the PHN, is to engage with practices, to really try to have that quality improvement process around some quality indicators, and then monitoring them.

And can I also perhaps mention that the other key thing that we have done here, and it gets to the point that I think Larissa made, one of the things that we have done in our primary health network, we now have health pathways, and so for us what we have got in the Sydney local healthcare district pathways, we now have six pathways devoted purely towards intellectual disability, and there is more under development. Health pathways is for us is an absolutely critical tool in supporting general practitioners in integrated care. So you were asking me before around what I would wish, why I would wish for that, and for a stronger uptake in that. I would also wish for pathways to be extended to include, where possible, allied health because at the moment allied health there is a lot of emphasis on general practice but as I said earlier, we have nearly 12,500 allied health in our region, and we have to focus on general practice, and our PHN will certainly be trying to put an increased focus also on inclusion of allied health.

MS WRIGHT: Thank you very much. Those are my questions.

CHAIR: Thank you. Commissioner Atkinson?

QUESTIONS BY THE COMMISSION

COMMISSIONER ATKINSON: I would like to ask Dr Goodger a few questions about the incentive payment.

Firstly, is it only paid to incentive networks or GPs, acknowledging what you have just said that at the moment it is not cognitive disability, how much is the payment actually, and is it based on something like the number of patients might go to a practice or where the practice is located and the demographics within the community?

Can you just tell us a little bit more? And you have said it is also about the responsibility of hours of care. Can you just tell us a bit more about it?

DR GOODGER: Yes, I can. So the payment is based on essentially $12,500 per quarter, $12,500 per quarter, they have to be - meet certain conditions under which they are able to participate as part of that. That is, they have to be accredited as well. And so part of that is also about demonstrating a commitment to quality improvement, so again, that is the nature, and it is based on what is called a standard whole patient equivalent, which I'm happy to provide further information in terms of a definition. So it is based, in effect, on the number of patients, but the technical term is the "standard whole patient equivalent", so it is not necessarily based on hours of care.

Practices, once they satisfy the criteria around being accredited, et cetera, are able to then receive that practice incentive payment, and the PHNs then go and work with those practices to try and develop up quality improvement plans around areas that have been identified by those particular practices.

Does that answer your question?

COMMISSIONER ATKINSON: Yes, thank you.

CHAIR: Thank you. Dr Goodger, I had just one question.

In your statement, you say that there are currently 13,000 people with cognitive disability in the region. Professor Trollor says that --- his estimate is, I think that 1.8 per cent of the population has an intellectual disability. That would suggest there should be around about 29,000 or 30,000 people. I see your footnote refers to a 2020 study that I have looked at, but what is the basis of the 13,000? It does seem a lot of people.

DR GOODGER: I appreciate that question. I think what we were drawing on evidence from our needs analysis, I'm happy to go back and provide to you the detailed reference.

We tend to cite Professor Trollor as the authoritative voice on this so I'm happy to go back to see what reference we cited in our needs assessment to justify that figure and provide that to you.

CHAIR: Yes, we would be grateful if you could do that, that would be helpful. Thank you very much.

Thank you for coming today, Dr Goodger, Dr Roeske and Dr Chalmers, for your evidence, and for the detailed statements that have been prepared to assist us. We appreciate your contributions to the Royal Commission. Thank you very much.

DR GOODGER: Thank you.

THE WITNESSES WITHDREW

MS WRIGHT: If we could adjourn for 10 minutes before Professor Trollor.

ADJOURNED **[3.22 PM]**

RESUMED **[3.29 PM]**

CHAIR: Yes, Ms Eastman.

MS EASTMAN: Commissioners, the final witness for today and indeed the final witness for this year is Professor Julian Trollor, and he is joining us on the videolink.

PROFESSOR JULIAN TROLLOR

CHAIR: Welcome back, Professor Trollor. Thank you very much for coming once again to the Royal Commission. You are a regular visitor. We are very pleased to have you. I think you have taken the oath or the affirmation as the case may be?

PROFESSOR TROLLOR: That is right, Commissioner.

CHAIR: Ms Eastman will now ask you some questions.

EXAMINATION-IN-CHIEF BY MS EASTMAN

MS EASTMAN: You are Professor Julian Trollor?

PROFESSOR TROLLOR: I am.

MS EASTMAN: You are a neuropsychiatrist with more than 30 years as a medical practitioner?

PROFESSOR TROLLOR: Yes.

MS EASTMAN: Since 2019 you have held the positions of Inaugural Chair of the Intellectual Disability and head of the Department of Developmental Disability Neuropsychiatry within the School of Psychiatry at the University of NSW?

PROFESSOR TROLLOR: I have.

MS EASTMAN: You have given evidence to the Royal Commission at Public Hearing 4, and the Commissioners have a copy of your very detailed statement and your CV.

Commissioners, may I remind you that that is Exhibit 4-09, and Professor Trollor's CV accompanies that part of the Exhibit.

Professor Trollor, you gave some written evidence to the Commission's Public Hearing 5 concerning COVID-19 and the impact of people with disability.

Commissioners, a copy of that statement is Exhibit 5-36.

More recently, Professor Trollor, you gave some short oral evidence but also provided a written statement to the Commission for Public Hearing 6 in relation to psychotropic medication and behaviours of concern.

Commissioners, a copy of that is Exhibit 6-20.

CHAIR: Thank you.

MS EASTMAN: Professor, when you gave evidence to the Royal Commission back in February, we did not cover every paragraph of your statement but we touched on the key issues.

Commissioners, you may recall that in Professor Trollor's written statement, he addresses the question of health, health workforce and training for all future doctors and nurses, in general training issues from paragraph 234 through to paragraph 254 part of Exhibit 4-09.

I will not ask you, Professor Trollor, to speak to all of those matters again, but is it a fair summary to say that your view was and I assume remains, that Australia's higher education sector plays a key role in preparing medical and nursing graduates to meet the diverse needs of healthcare of our population, and there needed to be quite specific training done to both care and treat people with intellectual disability? So at a high level, is that right?

PROFESSOR TROLLOR: It should do so. I don't believe it currently does.

MS EASTMAN: And your conclusion is that at the present time it fails to meet standards of both competency and capability and your view expressed to the Commissioners at paragraph 243 was if there is to be training, it ideally should be based on, you say, an overarching national competency framework which could be developed for health professionals in public settings. And you refer to a particular model you were involved in developing, a manual and a toolkit for NSW in relation to the mental health workforce. That is the document that the Commissioners have behind Tab 45, and that is the "Intellectual disability mental health core competency framework: A manual for mental health professionals". Is that right?

PROFESSOR TROLLOR: That is right, and there was an accompanying toolkit that assisted its implementation.

MS EASTMAN: I might ask you to come back to the framework as we go through your evidence, I am particularly interested in asking you about the development of core competency. But also, if this toolkit and the manual have been used, whether they have produced different or new outcomes. But Professor Trollor, you've followed the Royal Commission's proceedings over the past two days, I think you watched some of it, but you are also across all of the evidence, and we have provided to you a copy of the complete Tender Bundle. So I wanted really to gauge your reflections on what the Royal Commissioners have heard over the past two days, and to seek your views on a number of issues.

I think the first one to start with is this - the Commissioners have heard evidence over the past two days which seems to reflect a general agreement that more could be done there is a need for improvement, and there is a degree of goodwill. At the same time, that seems to reflect a position that has been in place for many years. So can I ask you why has the change been so slow, and at the present time whether you think there is any realistic prospect of change.

PROFESSOR TROLLOR: I think there are many contributors to the slow progress. I would like to point out that advocacy in this area has been present and forceful for decades, and that evidence of the health gap, including the mortality gap and the barriers to access to health care have been known about, and that we have seen no progress, for example, in medical primary --- medical and nursing degrees on teaching in this issue. So that is a stagnation. I think it stems from a number of root causes; primarily, disability and health separated some years ago, for good reason, but unfortunately the medical professionals left disability and people with disability behind. And so in that process of separation we saw a deskilling of medical workforce and a de-emphasis of training and exposure and awareness of the needs of people with disability.

So the current crop of medical professionals, including those at fairly senior levels now who are in the driving seat regarding the formation of curriculum content and

standards, lack the awareness of the health needs of people with disability, and therefore lack a vision for its inclusion in curriculum and standards. And so that is the situation we are in now. And we must seek to address that.

MS EASTMAN: Can I just explore that with you a little more. Is this something that you say is as a result of our history being one of segregation of people with intellectual disability in particular, often in large institutions, what came with de-institutionalisation was a move away from a medical model of disability and into an expectation that a social model would wrap around a person coming from an institution or no longer being required to live in an institution, and the expectation was that health and other services would meet the needs of people with intellectual disability? And so it hasn't, and so perhaps the specialist services that may have existed within institutions are no longer there. Is that what you are saying?

PROFESSOR TROLLOR: That is right, and we have seen this expressed also at higher levels in legislation and policy and regulation, in both disability and health services sectors. The National Disability Strategy has attempted to address this, and the current strategy which expires this year has a very strong focus on the health sector. In fact, it has a whole item with a series of points about the role and responsibility of the healthcare sector and professionals in it to meet the needs of people with disability. But it is very difficult for a document like that to mobilise a response in another compartment which views itself separately.

MS EASTMAN: What other factors contribute to why there has either been inertia or just a lack of translating the goodwill into action?

PROFESSOR TROLLOR: We have heard a lot of the lived experience of people with disability, and I would like to acknowledge those who have spoken in the current hearings, particularly Toni, Joshy, Dr Tracy, Corey, I think Dr Roeske, Laura, and others who might be listening, because what they have experienced is a lack of capacity in this area. These people have spoken strongly, but historically the voice of people with cognitive disability has not been heard. It has not been a forceful voice until more recently in advocacy and it has not been listened to when words have been spoken. So I think there is an issue of valuing people and valuing lives that comes into play. There is also an issue of crowding or perceived crowding in curriculum content, and a fear if we put the lives of people with disability and value them appropriately in standards and in curricula, that it may become too cluttered, and that potentially other groups with substantial health needs may also come forward requesting the same.

MS EASTMAN: The proposition we tried to develop over the witnesses in the last couple of days if we start with development of curricula, we see populations with the most profound health needs, and you start, and I'm trying not to use the expression "vulnerable" because I think it becomes an easy expression, but you look at where the complex health needs are in the community, and if you start to develop a curricula around those with the most complex needs or perhaps the most vulnerable in our communities, then you build from there. And it seems from the evidence that

that has not been the approach either to developing accreditation standards or developing what we teach in our efforts. How does one approach the development of curricula and/or the development of accreditation standards if the most difficult, the most vulnerable, and the most complex in our community are put to one side?

PROFESSOR TROLLOR: Associate Professor Nathan Wilson yesterday made a very important point, that perhaps it is about not so much the labelling as vulnerable or high need --- there is a value judgment in that --- but we must focus on groups we know have a substantial health gap, a substantial health inequality.

So my view here is that where we see the evidence stacking up, both from the point of view of the lived experience and then the population health data in backing that up, as well as good research that shows the barriers and enablers of access to healthcare for people with disability, including the lack of experience and competence of health professionals, we must take note of that. The purpose of the curricula are to train future doctors and nurses in meeting health needs. So where we show that that is failing, we must make sure we include those groups and their needs within the standards and the curricula content.

MS EASTMAN: You may have heard the evidence, or you have read the evidence of the Medical Deans, and that question of crowded curricula and also giving universities autonomy over what they teach, together with the fact that as undergraduates or in that graduate pathway, that is just the beginning and that the real learning occurs in practice. Do you have a view about what that means for the development of curricula across the 22 universities that teach medical programs in Australia and New Zealand?

PROFESSOR TROLLOR: My view is that attitudes are shaped very early in training, and that if one is going to engender valuing the lives of people with disability and their healthcare, that process needs to start at the earliest possible time, and continue, so that content must be represented in the standards for primary medical and nursing and allied health and relevant degrees. But there must also be a place for its presence in continuing medical education through the relevant specialist disciplines, and because some groups such as the people we are speaking about have very high health needs, there needs to be a place for sub-specialisation in certain specialties. And if you build that, that is a comprehensive fabric right from the earliest stages. But without the exposure early, it is highly likely that people will simply not be interested in this area.

We heard earlier from Associate Professor Beth Kotze about the influence of early exposure of psychiatry trainees in certain areas and the value that that was when they were undergraduates, to a future career in psychiatry. So this is a very similar situation.

MS EASTMAN: I want to be fair to Professor Murray, but I got a sense that unless there were accreditation standards requiring the university to teach specifically the care or issues around people with intellectual or cognitive disability, then it was not a

requirement for the university to do so. But he was also resistant to the idea that there be a mandatory component through the accreditation standards. Do you have a view on whether something should be mandatory or whether the goodwill should translate into a voluntary uptake in developing particular content in the undergraduate courses?

PROFESSOR TROLLOR: I have a fairly strong view on this issue, informed by lack of progress, despite having really good resources available for training of health professionals at different levels, including in primary medical and nursing degrees, we've seen no progress, and that is despite significant advocacy. So my sense is that unless there is a carrot or a stick, that it's simply not going to happen. And our recent publication looking at incremental change over a 20-year period in undergraduate medical curriculum suggested there had been no change; in fact, regression on some measures. So, simply without these being mandated in the standards and relevant documents, it simply will not occur. I have actually been through those documents and found that for someone like me who perhaps is less aware of the technical difficulties of that process, it is actually feasible to embed the sort of content we are speaking of in a way that sees it delivered across a range of different experiences within primary medical and nursing degrees, and in a way that is entirely feasible which does not create the sort of curriculum clutter that we have heard is a concern.

MS EASTMAN: How would that be done?

PROFESSOR TROLLOR: Perhaps if I could go to the relevant documents and work through them. I would like to perhaps outline the process of what I see is the way we could work through this, and using perhaps the primary degree programs as an example. In medical programs, for instance, we have a health practitioner regulation, national law, we have AHPRA as the regulation agency, we have the AMC in the instance of medical primary degrees, and the Code of Conduct, each of which are really important in this process. But if we turn, for example, to the accreditation authority standards for medicine, the AMC document that in my folder is labelled item number 3, if we look at that, that is divided into two parts; it contains both graduate outcomes and accreditation standards ---

MS EASTMAN: Can I just ask you to pause so the Commissioners can catch up with us. Tender Bundle Part B behind Tab 3.

PROFESSOR TROLLOR: Please let me know when you are ready.

CHAIR: Yes, go ahead.

MS EASTMAN: Yes, go ahead.

PROFESSOR TROLLOR: Yes, thank you. So if we look simply at the graduate outcomes under domain 1, "medical graduate as practitioner".

MS EASTMAN: Page 2 on the bottom of the page but "Domain 1" in the blue print

at the top of the page, is that right?

PROFESSOR TROLLOR: That is right. For Domain 2 now, "Clinical practice: the medical graduate as practitioner halfway down page 2, there are 15 points under "Clinical Practice", the first four of which, and then the subsequent 2.8 to 2.14, contain some domains which could include the construct of reasonable adjustments for people with cognitive disability within them. Each of those point I feel is highly relevant.

If I could ask you to turn the page to Domain 3 on page 3, "Health and Society: the medical graduate as a health advocate", there is ample opportunity to include health disadvantage in 3.1, and to broaden 3.4 to include broader health disadvantages, and ---

MS EASTMAN: And 3.2?

PROFESSOR TROLLOR: Well, and to include disability specifically in 3.2, and to include the barriers experienced by those with psychosocial or cognitive or other disabilities in 3.5, and including for example in 3.7 where it speaks about understanding and describing the role and relationships between health agencies and services, it would be a simple matter to include other agencies that are of high relevance to people with disability. For example, disability agencies or other agencies beyond health ---

MS EASTMAN: Yes, I have a note here for myself to ask you, in relation to 3.7 and 3.8, does an accreditation standard of this nature necessarily need to take into account the now roll-out of the NDIS, and that interaction between disability services and the NDIS, for example?

PROFESSOR TROLLOR: Yes, recognising that people have support across a range of different areas in life, it is natural that the standards - the graduate outcomes should be broader. And in, for example, 3.8 other groups, other than Aboriginal and Torres Strait Islander Peoples who experience health disadvantages that are very substantial and obviously embedded here, this point could be expanded to include groups experiencing health disadvantage.

If it is possible to move to Domain 4, "Professionalism and Leadership", it makes reference to provision of care in 4.1, provision of care the all patients in accordance with "Good Medical Practice: A Code for Conduct", yet when we look at the Code for Conduct it has two mentions of disability and a total, just on scanning it, of 26 mentions of Aboriginal and Torres Strait Islander Peoples, another very important group to include, but you can see that there is a gap then for people with a known health inequality, which could be addressed in that Code of Conduct.

It is possible also to consider broadening 4.8 to include other groups including those with disability. If we turn then to the accreditation standards, which are also a very important part of the puzzle, in terms of standard 1 on the top of page 5, there is

information about governance, and here - at 1.1.3 the medical education provider consults with relevant groups on key issues relating to its purpose, the curriculum, graduate outcomes and governance. We do not have a framework for including specific groups or a defined imperative to include people with lived experience in that process.

Likewise, in the Standard 1.4, "Educational Expertise", the educational expertise of Indigenous people is clearly recognised, but more broadly, could we not recognise lived experience experts?

I can continue on, perhaps, to Standard 4 on page 9, again "Learning and Teaching" in Standard 4, the medical educator at 4.1 employs a range of learning and teaching methods. Why shouldn't we at 4.1, 4.4 embrace those with diverse needs and lived experience including those with lived experience of disability?

And in Standard 8 on page 14, the Clinical Learning environment 8.3.3 partway down the page:

> *The medical education provider ensures the clinical learning environment provides students with experiences in the provision of culturally competent healthcare to Aboriginal and Torres Strait Islander peoples and/or Maori.*

This is an opportunity to consider other groups with health disadvantages. I do see the logistical difficulties of revising such documents, but I do see room to include the needs of people with cognitive disabilities recognising the substantial health in equality experienced by them.

COMMISSIONER ATKINSON: Professor Trollor, a couple of things.

First of all, in this document under Standard 7 with students, I was a little bit surprised to see in 7.2.2 where it says that:

> *The medical education provider has policies on the admission of students with disabilities .....*

It says.

> *..... and students with infectious diseases, including blood-borne viruses*

Which rather suggests that the admission of students with disabilities is a negative rather than a positive.

PROFESSOR TROLLOR: On the contrary, in the playout of this, this is the one of the good examples of where this point leads to substantial thinking and inclusive practice in medical education, for example, in my own university. So there is a very clear agenda that ensures that students with disabilities, and those with other conditions, are included, and certainly their needs are accommodated.

This is a powerful example of how there is value in having things written into the standards that then results in substantial change and effort and resources being assigned to it in medical degrees.

CHAIR: You need to read 7.2.2 with 7.3.2, that is, it makes it clear that this is designed to support students with disabilities or who may have infectious diseases, and so on.

PROFESSOR TROLLOR: That is right ---

COMMISSIONER ATKINSON: Can I ask you another question, sorry. Behind these standards is this document, "Procedures for the Development of Accreditation Standards", and I was wondering if in 2.1, which is paragraph 2, it describes how the proposed new and revised accreditation standards support or contribute to, and 2.1 is improving patient safety, effective care and health outcomes including for vulnerable members of the community and Aboriginal and Torres Strait Islander People.

If after, "including for vulnerable members of the community", there was inserted "and people with disabilities" that would then provide a support for all the things you have said in the standards to incorporate people with disabilities specifically. Has that idea got any sense to it?

PROFESSOR TROLLOR: Yes, I do agree, Commissioner. I think that is important, so with each of the curricula content we are speaking of, following it through from the relevant legislation through to the regulatory agency and the standards and inserting these necessary points will build that profile that enables medical schools to focus on this content and make use of a competency framework, should it be developed.

At the moment, my fear is a competency framework could be developed and we have developed some in other areas including in mental health, but they have not been used. Likewise, with funding from the Commonwealth Department of Health in 2014 we developed a national guide for all elements of the health service around intellectual disability and mental health.

Now, whilst that guide specified what health practitioners and their organisations could do in terms of actions at two levels, at a fundamental level and at an advanced level, there has been no change in the way services are provided or education has been provided, so you can see a lack of implementation or lack of capacity in such documents alone to influence what happens in practice.

CHAIR: Professor Trollor, in order to bring about significant change in any area, there are at least two steps. One is to formulate proposals for change, and another is to secure the implementation of the proposals? What then are the obstacles at each level --- let us take medical training or education as an example --- what are the obstacles that have prevented the change? You have identified the lack of change as

the problem. Why has that been so difficult?

PROFESSOR TROLLOR: I'm not entirely sure, but it relates to the earlier points we were discussing about the historical separation of disability and health, and largely the undervaluing of lives with people with disability. I feel those are the roots, and the lack of a voice in advocacy, and power that people with disability have in that context.

There is also a concern, I guess, at a fundamental level, this is perhaps a small percentage of the population that we are speaking about. If you don't recognise the very high needs of the population, then you would tend to diminish its importance and its place.

MS EASTMAN: I wanted to, before we came off the standards and went on to other topics, just take you back to standard 8.2.3.

PROFESSOR TROLLOR: Yes.

MS EASTMAN: This is the "Clinical Learning Environment" and we have heard in relation to trainees preparing for specialist accreditation through the various colleges, that the clinical learning environment is the primary way of educating and training. I want to come to that in a moment, but I want to start with this concept of culturally competent healthcare and that expression, "cultural competence" is defined if you go back to page ii.

PROFESSOR TROLLOR: Yes.

MS EASTMAN: Your suggestion is that 8.3.3 could be expanded to include other groups including people with intellectual disability. The way new AMC defines cultural competence you will see draws on some work of the Medical Council of New Zealand, and the footnote refers to a statement on cultural competence going back to August 2006, and I'm not sure whether you have had an opportunity to look at that. But if you take it from me, that this statement from the Medical Council of New Zealand was updated in 2019 and the language changed from "cultural competence" to "cultural safety", are you aware of that?

PROFESSOR TROLLOR: I'm not, and I have not had the opportunity to read the document.

MS EASTMAN: If one looks at the definition of cultural competence, which is a requiring an awareness of cultural diversity and the ability to function effectively and respectfully when working with and treating people of different cultural backgrounds, and then identifying particular professional qualities that the practitioner would need, that definition of "cultural competence" is a little narrow, is it not?

PROFESSOR TROLLOR: I agree. It is --- historically, culture has been viewed in a

certain way, but certainly with expansion of that construct this could be a way of including people with cognitive disabilities.

MS EASTMAN: And you have referred to the concept of reasonable adjustments. To what extent does cultural competence need to have a meaning that reflects not only the Australian legal context, but also a broader concept that would include people with intellectual disability?

PROFESSOR TROLLOR: I think ---

MS EASTMAN: I'm testing you on 8.3.3 because particularly about clinical learning environments, that is important, but I'm putting to you I'm not sure that the definition of culturally competent healthcare is an appropriate definition to ensure that it captures the healthcare needs of people with intellectual disability, given its definition in the standards. So what I'm putting to you is that, does that definition of "cultural competence" or "cultural safety" need to be revisited?

PROFESSOR TROLLOR: It does, yes. The basic gist here is that we are trying to ensure that medical graduates are able to overcome or assist a person from a diverse cultural background in overcoming any barriers they may experience in their healthcare journey, and so naturally extending that if you were to do the same for people with cognitive disabilities, the parallel is in provision of reasonable adjustments that are tailored to that individual's needs.

MS EASTMAN: If you then take a step forward, and in the bundle this is the document behind Tab 4, these are the standards for assessment and accreditation of specialist medical programs and professional development programs by the AMC in 2015. If you turn to page (v) in this document under the glossary, there is a slightly different definition of "cultural competence" and it picks up that context of cultural safety but it still goes back to a 2006 document.

And, just looking at that definition, the AMC is drawing on the Medical Council of New Zealand's definition but it also draws on the Royal Australian College of General Practitioners' explanation of "Cultural Safety". In light of what I have suggested to you for the AMC accreditation for what we might call primary medical programs, there seems to be a bit more nuance, doesn't there, in the concept of cultural safety in the accreditation standards for specialist medical programs, and do you still think there is some work to do?

PROFESSOR TROLLOR: I think this is a better definition but there is still some room to expand that construct. The safety for people, and the terminology that is used there is perhaps not quite specific enough for the health needs of people with disability in terms of provision of reasonable adjustments.

MS EASTMAN: Have you turned your mind to the specialist accreditation guidelines, on what amendments, if any, could be incorporated in relation to specialist training?

PROFESSOR TROLLOR: I have not had that opportunity but it is feasible to work through that document. Essentially I was using the primary medical degree standards as a --- graduate outcomes and accreditation standards as an exemplar. Essentially this process needs to be worked through for each primary degree that is relevant, including medicine, nursing, allied health, psychology and so on, dentistry, so there is a raft of material to look through and this would need to be done, I think, with a close consultation and engagement of people with disability to ensure that the types of changes being suggested reflect the needs of people with disability.

MS EASTMAN: Did you want to say anything now about the training and education in the context of specialist pathways? And we asked various colleges today what is the general content in relation to intellectual and cognitive disability in the programs, but also specialist pathways.

I think there is a little bit of a dead end when it comes to any specialist pathways to become a specialist in intellectual disability, and you might recall Dr Cathy Franklin spoke about this and the Royal Commission heard her evidence in Public Hearing 6, and I think the Commissioners asked, during that Public Hearing, Dr Law and Dr Torr what their training had been, and in effect they had to work it out for themselves based on their interests.

So what are your views, if any, on a specialist pathway? Both at a general level from content but also the specialist pathways.

PROFESSOR TROLLOR: Thank you, I think there are two groups that we have not spoken about, both the existing medical workforce and how to do deal with that issue, I hope we will come to that, and medical specialists.

I think psychiatry is a good example here because in Australia psychiatry is slightly more advanced in its evidence collection and thinking. So for example, what we have done for, within psychiatry, is conducted a series of studies. Firstly, scoping studies that look at whether specialised services should be developed, and if so, exactly what they should look like. We have conducted studies of workforce capacity in the area of intellectual and developmental disability mental health. We have conducted studies regarding the level of support within current psychiatry - psychiatrists across Australia and New Zealand for the development of sub-specialty training. And we have characterised the capabilities of the workforce in psychiatry in Australia and New Zealand to deliver effective treatments.

We have also surveyed the capacity to conduct specialist training, host specialist training positions, and done an extensive review of the fellowship program content and made recommendations for enhancement in stage 1 and 2 in training, you have heard about that today --

MS EASTMAN: I have, and I did not get to ask Dr Kotze this, this but our understanding is that the recommendations made for incorporation in stage 1 and 2

have not been accepted, but some of the other recommendation have, is that right?

PROFESSOR TROLLOR: At this stage, the only recommendations that have not been accepted are to do with stage 1. Stage 2 is under discussion, and then the additional component, by using an inclusive research practice with people with disability, those who support them, and experts in the field, we have developed a proposed curriculum for specialised training to train the specialist psychiatrists in intellectual and developmental disability mental health.

And this curriculum proposal has been put to the College but awaits a response. In general, as you have heard from Associate Professor Beth Kotze today, it is very much supported within the College, to eventually institute a program of specialised training and certificate training based on such a proposal.

MS EASTMAN: What is the time frame on that? Have you been given any indication?

PROFESSOR TROLLOR: I haven't. I have had discussions with successive college presidents, all of whom have indicated support for this area. I don't doubt that it will occur. Part of the issue here is that we were able to do this work through generous funding that was provided for the different studies I have mentioned --- originally disability services and then NSW Health. However, the funding is for specific projects and that has now ceased, so I have now handed over all those recommendations to the College and have limited resources with which to drive that project further.

MS EASTMAN: There needs to be a commitment both in terms of funding and implementation of these recommendations.

PROFESSOR TROLLOR: Yes, but of course the realist in me realises that running such a specialised training program involves not just the curriculum being accepted, but it involves the College supporting the administration of an expert certificate, and it involves the States coming to the party and agreeing to fund advanced training positions, and it requires supervisors to step up and supervise those training positions. So there are a number of things that need to come together.

At present, there are no training positions where a trainee position is guaranteed in terms of its funding for ongoing specialisation in our field. We try and cobble together funding from different competitive sources, you heard earlier today from the Health Education Training Institute, which is one source of training for a one-year specialised training experience in this area, and the STP Program from the Commonwealth, but apart from that there are no guaranteed funding sources to support specialised or advanced training at present that I'm aware of anywhere in Australia or New Zealand.

MS EASTMAN: I'm conscious of the time and conscious that the Commissioners may have questions for you.

One topic I do want to cover before we finish is what is currently happening with the national roadmap, we heard evidence in February before COVID-19 that there was going to be action taken, and then I think there has been recent work and meeting in November. But Commissioners, may I check, before I turn to that topic, that the Commissioners have any particular questions?

COMMISSIONER ATKINSON: I did have a question. In the first panel we had, there was some acceptance that there should be a national capability framework, there being some distinction made between a capability and a competency framework. Do you see any distinction between the two and if so, what is it?

PROFESSOR TROLLOR: Look, I'm not the expert in this area, but I'm aware that most of what I have seen in our own undergraduate program is based on capability rather than competency, and I think there is a distinction between the two, they are slightly differently defined, and to be honest I have to refer back to the formal definitions, both. I don't think the distinction diminishes the argument, the argument is that something should be done that is prescribed at the highest level, that drives that teaching, whether it is a competency or otherwise is probably not a core issue from my perspective.

COMMISSIONER ATKINSON: Thank you.

COMMISSIONER BENNETT: No, thank you.

MS EASTMAN: So I think you wanted to talk about workforce. So I don't want to overlook that, and if there is any particular points that I have overlooked that you wanted to discuss as well, can I invite you to make those comments and then we will end on what has occurred more recently with the national roadmap.

PROFESSOR TROLLOR: I think we need to deal with other medical colleges, I think we have a blueprint in what we have done within psychiatry so far. But I will leave that perhaps at this point. In terms of the existing workforce we have essentially a medical workforce that is currently ill-equipped, and we, for example, surveyed the NSW mental health workforce and asked them about what they see is their role and how confident they feel and their training needs. And it is unsurprising that - and the publication I refer to is by my colleague Janelle Weise and myself in 2017, in which we looked at the preparedness and training needs of the NSW public mental health workforce.

In general, the participants in our study, and there are just over 600 of them, I think, if I may recall, agreed that intellectual disability mental health was a core component of what they felt they should be doing, they felt people had a right to effective treatment, and the same access to their services, but the resources available to them were very poor. They did not feel they had enough time to train in the area, and they reported low confidence in key clinical domains.

So this essentially is the situation to be likely experienced by not just the mental health workforce but by all health practitioners in our public health system. So what can we do about that? I think there we need to take some action. We would need essentially to think about how we draw on the Disability Inclusion Action Plans at a State level, and implement them. And perhaps that is a lever for making sure there is minimum mandated training in this area.

I think I have said to others before that I'm required as a Local Health District employee to do mandatory training in different areas, and assigned to me are a range of mandatory modules I must complete at a certain frequency, some of which are completely irrelevant to my day-to-day practice, including understanding the emergency signs in the maternity ward and in paediatric health care, none of which I do. These could be easily removed, and content such as what we are describing that is relevant in every day care for people with disability could be included. What else can we do? Obviously we need to ensure that the councils of presidents of medical colleges and perhaps the professional bodies and specialist colleges, and even consider perhaps the National Quality and Safety Service Standards, might have a view to including this content and seeing it as relevant and important for those that they govern.

They are some ideas, but essentially I think we need to contemplate this really in-depth, and have a clearly defined process for each component of the workforce.

MS EASTMAN: How long is that going to take?

PROFESSOR TROLLOR: The simple answer is that if it is done properly it takes some time, but it is proportionate, or inversely proportionate to the resources that are available. Frankly, where are the resources currently.

MS EASTMAN: Can I move then to the Second Roundtable. That was held on 2 November, convened by Mr Cotterell, the First Assistant Secretary of Primary Care Division in the Commonwealth Department of Health. You attended that roundtable?

PROFESSOR TROLLOR: Yes, I did.

MS EASTMAN: Commissioners, you have a copy of the records of the roundtable behind Tab 44 in your Tender Bundle B Volume 1. The notes indicate, Professor Trollor, that you outlined the key risk factors and barriers to healthcare for people with intellectual disability and gave an overview of their health status. I assume that that is a conversation that you feel that you have had thousands of times. Would that be right?

PROFESSOR TROLLOR: That is correct. A summary of the evidence was given.

MS EASTMAN: What came out of the recommendations for that roundtable, which appear on page 7 of the notes, is a number of high-level steps and considerations in

further developing the roadmap. And that included consideration of identifying specific measurable outcomes to highlight the need of people with intellectual disability to be supported to make decisions about their health, and ensuring integration between the roadmap and other major reform agendas which were identified. And there is going to be some small group discussions, but the plan is for people to come back on 24 February next year, but there was also, was there not, a targeted group discussion on curriculum on healthcare for people with intellectual disability and that was held on Thursday, 19 November, and you presented a PowerPoint slide of that?

PROFESSOR TROLLOR: That is correct.

MS EASTMAN: And probably said things that you feel you have said thousands of times before. Is that right?

PROFESSOR TROLLOR: With a focus on medical education similar to what we have been discussing today.

MS EASTMAN: The Commissioners have a copy of the notes from that meeting, and also the relevant attendees, some of whom were witnesses in the proceedings over the past two days and also earlier in other public hearings that the Royal Commission has conducted.

Reading those notes, can I ask you where is the curriculum reform and curriculum development heading with respect to the roadmap, and what does the Royal Commission need to know and understand about what process is presently underway under the Commonwealth Department of Health's auspices?

PROFESSOR TROLLOR: Essentially we await the detailed response from the Commonwealth on this issue. So the series of meetings that occurred have been very productive and important to shape the National Roadmap. The original intention, I think, of the National Roadmap was as a relatively small piece of work that as the needs have been exposed, seems to have grown in size and become complicated by the COVID-19 situation. But at present it is still unclear what the next steps will be and what the Commonwealth will direct to happen.

There was substantial support for the argument that more needs to be done in terms of training and education. But as we have heard similar to the hearing you have conducted, some reluctance to contemplate that in terms of it being mandated in major overarching stands. So we are yet to understand, really, where this will head to next.

MS EASTMAN: I do not want to end on a negative note, but looking at the key points raised in the discussion, and they are reproduced on page 4 and page 5, it seems that what came out of the meeting on 19 November somewhat reflects many some of the views that the Royal Commissioners have heard over the past few days, which is very much focused on identifying the difficulties, so the crowded

curriculum, the fact that it is complex, it will take time, there is a lack of expertise, et cetera. That is why I'm asking you, where is this heading? Is it a discussion that leads to yet again clear identification of problems that have existed and have been known now for decades? Or do you see that this process is likely to actually effect some real change?

PROFESSOR TROLLOR: I have confidence in those conducting the roundtable and the series of meetings that some definitive action will be taken. I'm unsure of the constraints regarding budget that is assigned to this particular initiative in the Commonwealth. I would think that that may be a potential piece of the puzzle which if insufficient will not allow the sorts of reforms we are talking about to be given.

MS EASTMAN: Where is the lever to effect change? Does that come at a state or territory level? Does it come at a Commonwealth level? Does it come at the colleges? Is it the Medical Deans? Is it the AMC? I mean, where is the lever that at least will be the catalyst for change? What is your view on that?

PROFESSOR TROLLER: The best evidence we can draw on for guidance is from international jurisdictions such as the UK, where it is required both a legislative framework in the *Equality Act 2010* and also substantial listening to the lived experience of people with disability, including to the experiences of Paula McGowan and her family which have catalysed now a trial of training for health professionals regarding the needs of people with intellectual disability and autism. This has been supported at the highest levels, including within the UK Parliament. My sense is that unless we have this whole issue aired and discussed at high-level meetings, including things like the COAG health meetings led by the Minister, the Commonwealth level and supported by state and territory Health Ministers, we will not have a definitive action.

MS EASTMAN: Professor Trollor, thank you once again for being so generous in your time and expertise with the Royal Commission. Thank you also for your reflections on the hearing over the past about two days.

Commissioners, that concludes the evidence for these two days. I'm about to ask you whether we may add a third day to this public hearing to explore some of the other health professions.

CHAIR: I will see if there are any further questions of Professor Trollor.

COMMISSIONER ATKINSON: No, thank you.

COMMISSIONER BENNETT: No, thank you.

CHAIR: Again, I fully endorse, and I'm sure my colleagues fully endorse the thanks that Ms Eastman has expressed to you, not only for your evidence today and you reflections, but on all of your contributions to the work of the Royal Commission. I think you should derive, if I may say so, a considerable satisfaction from the

influence your work has had so far on our thinking and I'm sure will continue to have an impact. Thank you very much indeed.

PROFESSOR TROLLOR: Thank you, Commissioner.

THE WITNESS WITHDREW

CHAIR: Ms Eastman.

MS EASTMAN: Commissioner, as I said, our initial hope was to complete this hearing in one day. As our preparations for this hearing developed, we realised that we needed two days. But we would very much welcome the opportunity to explore some of the other areas of health including dentists, pharmacists, psychologists and perhaps some other allied health disciplines. We anticipate that we should be able to do that in an additional day's hearing sometime early in 2021.

CHAIR: I think you proposed certain directions, and I would propose to make those directions to allow that to happen.

On the whole, estimating one-third of the time actually required is pretty good for lawyers. Underestimates at times ---

MS EASTMAN: Said like a true retired judge.

DIRECTIONS

CHAIR: The directions that we shall make to enable this to occur are these:

One, by Friday 22 January 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.

Two, the Royal Commission will schedule a one-day hearing on Tuesday 2 March 2021 as a continuation of this Public Hearing 10, which will involve the further exploration of the education and training of health and allied professionals in the care and treatment of people cognitive disability.

Ms Eastman, nothing else from you?

MS EASTMAN: Nothing more from me.

CLOSING

CHAIR: I want to make a brief statement.

This, as Ms Eastman has pointed out, is the last day of public hearings for the Royal Commission for this very difficult and challenging year, now coming to a close. Despite the difficulties, we, the Royal Commission, have managed to hold six hearings since we resumed in August 2020, after the hiatus caused by the COVID-19 pandemic and the restrictions associated with that. We have held hearing number five to hearing number ten, the hearing that occurred this week.

The most important aspect of the hearings that we have held has been the evidence given by so many people with disability and also their family members. I want to express, on behalf of all of the Commissioners, our profound thanks and appreciation to all the people who, with disability, have been prepared to give evidence in our public hearings. As we have said on a number of occasions, this is not an easy thing for anyone to do, particularly when nearly all the evidence has had to be given from remote locations, using temperamental technology.

Over these two days we have heard from Kylie Scott, Corey Burke, Tara Elliffe, Joshy Mitchell and Laura Naing, of course from Joshy's mother Ms Toni Mitchell. The evidence we have heard this week and all at the other hearings that have been held during 2020, from people with disability, that evidence has both informed and enriched us, and it has been a privilege to hear the stories of the people who have given evidence, and also their suggestions as to how Australia can become a more inclusive society, thus preventing violence, abuse, neglect and exploitation of people with disability.

I have referred at other hearing to the superb work done by Senior Counsel and Counsel, the Office of the Solicitor Assisting and the various branches of the Royal Commission who have assisted in preparation for and the conduct of the hearings. We have covered a remarkable range of topics during our hearings in less than ideal circumstances.

Today, I just want to make specific mention of the teams who have provided support to witnesses with disability before, during and after giving evidence. We are, of course, committed to ensuring that witnesses, or for that matter anyone engaging with the Royal Commission, is not re-traumatised, is fully supported, and feels safe and comfortable when giving statements and preparing statements and giving evidence.

The staff within the Royal Commission, especially the lawyers within OSA and the counsellors who provided support to people with disability giving evidence, have done an outstanding job throughout this year. I know it is a source of immense satisfaction to them when this happens quite regularly, someone with disability who has given evidence expresses appreciation for the support provided by the counselling and legal teams. These hearings would not be possible without the support that has been provided to witnesses with disability, and their families, and the Commissioners are deeply grateful to those who have provided that support.

I also want to express, on behalf of the Royal Commission, our appreciation to all

other witnesses who have given evidence. Overwhelmingly, as we saw over the last two days, great care and thought has gone into the preparation statements and the oral evidence that has been given by witnesses. We now have an enormous amount of material to work with, and we will obtain very great assistance and guidance from it. Finally, I want to express thanks to Senior Counsel, Kate Eastman SC, Dr Kerri Mellifont QC and Lincoln Crowley SC, and to the junior counsel, all of whom have contributed mightily to our hearings, including of course Ms Wright, who has appeared this week.

It remains only to wish everybody who has participated in the hearings, or followed the work of the Royal Commission during this year, good health, contentment and the opportunity for relaxation during the holiday period. We all fervently hope that 2021 will prove to be a better year.

We will now adjourn.

ADJOURNED AT 4.34 PM UNTIL TUESDAY, 2 MARCH 2021

Index of Witness Events

Index of Exhibits and MFIs