Royal Commission
into Violence, Abuse, Neglect and Exploitation
of People with Disability

Public Hearing **Report**

Public hearing 10

Education and training of health professionals in relation to people with cognitive disability

Sydney
15 - 16 December 2020
and 2 March 2021

Commissioners

The Honourable Ronald Sackville AO QC

Ms Barbara Bennett PSM

Dr Rhonda Galbally AC

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Contents

Overview and summary

1. In December 2020 and March 2021, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Royal Commission) conducted a public hearing in Sydney to investigate the education and training of health professionals in the provision of health care to people with cognitive disability (Public hearing 10). This is the Report of three Commissioners who participated in the hearing: the Honourable Ronald Sackville AO QC (the Chair), Ms Barbara Bennett PSM and Dr Rhonda Galbally AC.[1]

2. Investigating barriers to effective health care for people with cognitive disability is a priority for the Royal Commission.[2] This priority is informed by the Royal Commission's Terms of Reference. The Terms of Reference require the Royal Commission to inquire into what governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, considering the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts.[3]

3. The Royal Commission's Terms of Reference also recognise Australia's obligations under international law to take appropriate measures to promote the human rights of people with disability.[4] These obligations are set out in the *Convention on the Rights of Persons with Disabilities (CRPD),* to which Australia is a signatory. The right to the highest attainable standard of health without discrimination on the basis of disability is specifically protected under the *CRPD.*[5] Among other things, this means that health professionals must provide care of the same quality to people with disability as to other people.

4. The right to health care has been a core part of the Royal Commission's work:
    - Public hearing 4 was the first public hearing of the Royal Commission dedicated to examining the health care and services provided to people with cognitive disability in Australia.
    - Public hearing 5 examined the experiences of people with disability during the ongoing COVID-19 pandemic.

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1 The Honourable Roslyn Atkinson AO also participated but resigned her commission with effect from 24 June 2021. She has therefore played no part in preparation of this report.

2 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Interim Report,* October 2020, p 267; Transcript, Ronald Sackville (Chair), Public hearing 4, 18 February 2020, P-3; Transcript, Ronald Sackville (Chair), Ceremonial hearing, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Brisbane, 16 September 2019, P-22 [9].

3 *Letters Patent* (Cth), 4 April 2019 amended 13 September 2019.

4 *Letters Patent* (Cth), 4 April 2019 amended 13 September 2019, preamble.

5 *Convention on the Rights of Persons with Disabilities,* opened for signature 30 March 2007, 999 UTS 3 (entered into force 3 May 2008), art 25.

- Public hearing 6 inquired into psychotropic medications and their use on people with cognitive disability when they display 'behaviours of concern'.
- Public hearing 12 further considered the experiences of people with disability in the context of the Australian Government's approach to the COVID-19 vaccine rollout.

5. During Public hearing 4, Public hearing 5 and Public hearing 6, the Royal Commission heard about the multiple barriers to effective health care and high rates of premature and potentially avoidable deaths of people with cognitive disability.[6] Therefore, the training of health professionals is also an important topic when considering the barriers to effective health care for people with cognitive disability.

6. The Report for Public hearing 4 identified issues that the Commissioners who sat on that hearing considered should be the subject of further inquiry. These included the following issues about the education and training of health professionals:

- the nature and content of training about cognitive disability provided to people studying to become health professionals or already practising as health professionals
- the extent to which people with cognitive disability, their families, carers or support persons are involved in the design and delivery of training programs
- the effectiveness of education programs designed to improve communication between health professionals and people with cognitive disability
- the effectiveness of education programs designed to address health professionals' unconscious bias and negative assumptions about the value of lives led by people with cognitive disability
- the nature of training and education required to equip health professionals with the skills, knowledge and understanding necessary for the correct diagnosis of conditions experienced by people with cognitive disability, and to avoid diagnostic overshadowing.[7]

7. Public hearing 10 addressed those issues.

8. This Overview presents the findings and recommendations of the Commissioners in response to the evidence heard in Public hearing 10. The status of this Report and the findings and recommendations is explained at [31]-[35] below.

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6 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 4: Health Care and Services for People with Cognitive Disability,* October 2020; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 5: Experiences of people with disability during the ongoing COVID-19 pandemic,* November 2020; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 6: Psychotropic medication, behaviour support and behaviours of concern,* June 2021.

7 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 4: Health Care and Services for People with Cognitive Disability,* October 2020, [525].

Findings

Finding 1

Education providers of entry-level health practitioner programs do not adopt a consistent approach to teaching about the health care of people with cognitive disability (cognitive disability health). Education providers in a given health discipline vary considerably in how much they teach cognitive disability health content.

Finding 2

Education providers of health practitioner or postgraduate medical programs are not currently required to deliver education or training about specific competencies or capabilities in cognitive disability health. Because of this, students and trainees have variable exposure to cognitive disability health issues. A capability or similar framework developed across health professions would assist education providers to develop or enhance their education and training programs so that future practitioners, including specialists, develop appropriate skills in cognitive disability health.

Finding 3

1. The development of a cognitive disability health capability or similar framework is an available and critical strategy to ensure that cognitive disability competencies, curricula content and resources are developed across health practitioner programs at entry-level and postgraduate level and as part of in-service training and continuing professional development (CPD).
2. Successful development and implementation of a cognitive disability health capability framework (capability framework) requires leadership of the education, regulatory and professional bodies responsible for the education and training of health professionals. It also requires that people with lived experience of cognitive disability co-design the framework. Those leading the process will need to take responsibility for consultation with bodies responsible for education and training across health professions and for implementing an effective co-design process.
3. We are satisfied that the Australian Medical Council and the Medical Deans Australia and New Zealand have the necessary skills, expertise, commitment and established networks with the other stakeholders to assume this role and lead this inter-disciplinary work.

4. The steering committee that is established to progress the framework should include bodies and people who:
    a. have lived experience of cognitive disability
    b. have a demonstrated capacity to partner with people with lived experience of cognitive disability
    c. have experience in developing and implementing competency or similar frameworks
    d. have clinical skills in cognitive disability health recognised by peers
    e. represent the continuum of health practitioner education and training, including entry-level and postgraduate programs, in-service training and CPD
    f. will be responsible for implementation of the framework in educational and health care settings.

Finding 4

Curriculum development relating to cognitive disability health must include skills in interprofessional practice and integrated care.

Finding 5

Unless accreditation standards are revised, there is unlikely to be substantive change to educational curricula to incorporate enhanced training on cognitive disability health. Generalised accreditation standards are unlikely to be sufficient to ensure changes are made to curricula to embed cognitive disability health capabilities.

Finding 6

The inclusion and comprehensiveness of cognitive disability health content in health practitioner programs have depended significantly on individual academics to support or 'champion' its inclusion. Curriculum content in this area is variable, inconsistent and prone to being discontinued if the champions leave or are no longer available to provide leadership. There is scope to incorporate and integrate cognitive disability health content in health practitioner programs, and to do so in a sustainable manner.

Finding 7

Clinical placements are a vital feature of training to prepare health practitioners for practice. They provide an important opportunity to expose students to patients or clients with cognitive disability under supervision. However, currently:

a. Clinical placements do not consistently prepare students with skills to provide care for patients with cognitive disabilities.

b. Not all students have access to clinical experiences relevant to cognitive disability health.

c. While education providers expect students to be exposed to patients with cognitive disabilities in clinical placements, they do not systematically ensure opportunities are provided to develop skills in cognitive disability or that clinical placement providers are equipped to provide those opportunities.

d. Settings outside the traditional clinical environments of public hospitals need to be expanded to provide more opportunities for supervised learning with patients with cognitive disabilities, particularly in medicine.

e. Funding structures are critical to the ability of education providers to provide a broader range of opportunities for supervised clinical placements in cognitive disability health.

Finding 8

Health professionals often lack access to relevant CPD training, particularly in the area of intellectual disability health, across the medicine, nursing, dentistry, pharmacy, psychology and speech pathology professions.

Finding 9

Experts and education providers agree that it would be valuable to centralise and share resources to support improved education, training and practice in cognitive disability health. There is also broad support for the establishment of a network of centres of excellence or a national centre of excellence to bring together expertise and lead research in cognitive disability health to support the translation of research findings into practice nationally.

Recommendations

9. Based on the evidence at Public hearing 10, Counsel Assisting's Submissions identified ten recommendations, including one alternative recommendation. The Australian Government supported eight recommendations in principle and one recommendation in full. It also supported in part the recommendation directed to the Australian Government Minister for Health and Aged Care, and made observations on the form of four recommendations.[8] The Australian Government also considered that the evidence supported an additional recommendation to mandate curriculum reform through accreditation standards. We have taken these observations into account in framing the recommendations in this Report.

10. The 12 recommendations made in this Report broadly follow the recommendations proposed in Counsel Assisting's Submissions, but with some modifications.

11. While Counsel Assisting proposed a single recommendation about the development and implementation of a cognitive disability health capability framework or similar framework (and an alternative form of that recommendation), we make five recommendations on that subject. The five recommendations address:

    - the leadership and process for developing the framework and associated initiatives (Recommendation 1)
    - the scope and content of the framework (Recommendation 2)
    - funding and other support from the Australian Government (Recommendation 3)
    - reporting on progress (Recommendation 4)
    - the Health Council's governance of the framework beyond the life of the Royal Commission, as the Ministerial Council with oversight of the National Scheme under section 11 of the *Health Practitioner Regulation National Law* (Recommendation 5).

12. The reporting recommendation (Recommendation 4) will allow the Royal Commission to make further recommendations if necessary during the life of the Royal Commission to address any delays or other challenges in the process.

13. We also make an additional recommendation, not proposed by Counsel Assisting, directed to the Colleges which participated in Public hearing 10 (Recommendation 11).

8 Submissions of Counsel Assisting, Public hearing 10, 3 May 2021, DRC.9999.0072.0133, Recommendations 1, 2, 6 and 7.

Recommendation 1

1. The Australian Medical Council and the Medical Deans Australia and New Zealand should take a joint leadership role to establish a steering committee to develop and co-design:
    a. a cognitive disability health capability framework (capability framework)
    b. associated initiatives that include:
        - a core set of shared, high quality and accessible learning resources and tools for assessing cognitive disability health capabilities
        - an implementation plan for embedding the capabilities from the framework in curricula in education and training programs for health practitioners across all training stages.
2. The steering committee should include people or representatives of bodies that have:
    a. lived experience of cognitive disability
    b. a demonstrated capacity to partner with people with lived experience of cognitive disability
    c. experience in developing and implementing competency or similar frameworks
    d. clinical skills in cognitive disability health
    e. responsibilities for the implementation of the framework in educational programs and health care settings.
3. The steering committee should design and implement an effective process for co-designing the capability framework and associated initiatives with people with cognitive disability, their families and carers, and advocacy groups representing people with cognitive disability.
4. The steering committee should also ensure there is comprehensive consultation on the development and implementation of the capability framework and associated initiatives with:
    a. all peak bodies representing medical, nursing, dental, pharmacy and allied health practitioner education
    b. accreditation authorities
    c. health practitioner regulatory bodies
    d. Australian, state and territory health system education and training bodies.

Recommendation 2

1. The capability framework should be designed to:
    a. apply to all registered and non-registered health professions and address core capabilities and profession-specific capabilities, as necessary
    b. enhance health practitioner curricula across all training stages, including entry-level and post-graduate programs, in service training and CPD.
2. The capability framework should specify the core knowledge, skills and attributes required for the provision of quality health care to people with cognitive disability, including intellectual disability. The framework should incorporate content appropriate to the various stages of education and training. The content should include:
    a. understanding disability and attitudes towards people with disability
    b. the impact of the health care system and health service delivery on people with cognitive disability, including the barriers to quality health care they may face
    c. specific requirements to ensure accessibility, and the provision of reasonable adjustments and supports, including communication skills
    d. understanding, preventing and managing 'behaviours of concern', particularly through means other than restrictive practices
    e. appreciating the importance of skills necessary to work collaboratively with families, support people, advocates, and professionals from various health and social disciplines
    f. other general competencies that might apply to a range of vulnerable patient groups, including:
        - working effectively with people with chronic and complex health needs
        - working effectively with people from diverse backgrounds, including First Nations people, people from culturally and linguistically diverse communities and LGBTQI+ communities
        - sourcing information, appropriate services and professional support.

Recommendation 3

The Australian Government should facilitate and support the development and implementation of the capability framework and associated initiatives. To this end:

a. the Australian Government should consider allocating the funding committed to the curriculum development initiative in the *National Roadmap for Improving the Health of People with Intellectual Disability* or provide additional funding to support the development of the capability framework

b. the Australian Government Department of Health should offer and provide secretariat support to the steering committee proposed in Recommendation 1.

Recommendation 4

The steering committee leading the development of the capability framework should report to the Royal Commission within eight months of the publication of this Report on the progress in implementing Recommendations 1 and 2.

Recommendation 5

Beyond the life of the Royal Commission, the Health Council should have responsibility for further development and implementation of the capability framework and associated initiatives to enhance cognitive disability health education and training.

Recommendation 6

The accreditation authorities for registered health professions and the peak professional bodies for non-registered health professions should review the accreditation standards and evidence requirements for education providers and consider whether cognitive disability health is sufficiently covered. If it is not, they should amend their accreditation standards or evidence requirements (as the case may be) accordingly.

Recommendation 7

The accreditation authorities for registered health professions and the peak professional bodies for non-registered health professions should encourage or mandate education providers to:

a. develop curriculum content relating specifically to cognitive disability health and do so in conjunction with people with cognitive disability

b. deliver such content using inclusive teaching practices and do so involving people with cognitive disability where possible.

Recommendation 8

The accreditation authorities for registered health professions and the peak professional bodies for non-registered health professions should report to the Royal Commission within eight months of the publication of this Report on progress in implementing Recommendations 6 and 7.

Recommendation 9

Education providers should explore with clinical placement providers, across the range of settings in which clinical placements take place, increased opportunities for student learning and development in cognitive disability health, including as part of interprofessional teams.

Recommendation 10

As part of the implementation of the *National Roadmap for Improving the Health of People with Intellectual Disability* (July 2021), the Australian Government should consider mechanisms to enhance funded supervised clinical and work-based training placements to train students in providing quality health care to people with cognitive disability. This should include enhanced financial support for clinical placement and supervision in community settings.

Recommendation 11

The Royal Australasian College of Physicians (RACP), Royal Australian and New Zealand College of Psychiatrists (RANZCP), Australian and New Zealand College of Anaesthetists (ANZCA), Royal Australian College of General Practitioners (RACGP), Australasian College of Emergency Medicine (ACEM) and Australian College of Rural and Remote Medicine (ACRRM) should each:

a. develop specialised training content in cognitive disability health for different areas of specialisation, building on the capability framework and the core set of learning resources, so that future specialists can develop skills and competencies in cognitive disability health

b. expand and promote pathways for sub-speciality training in cognitive disability health.

Recommendation 12

The Colleges RACP, RANZCP, ANZCA, RACGP, ACEM and ACRRM, the Australian Dental Association and professional bodies responsible for CPD in the nursing and allied health professions should each:

a. review CPD programs in their respective health discipline or specialty to determine whether CPD for the provision of health care to people with cognitive disability, including intellectual and/or developmental disabilities, should be enhanced

b. promote the development of CPD opportunities on the provision of health care to people with cognitive disability, including intellectual and/or developmental disabilities

c. raise awareness of such CPD opportunities among members

d. report to the Royal Commission within eight months of the publication of this Report on progress in implementing this Recommendation.

Part 1: Introduction and background

14. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability was established in April 2019 under letters patent amended in September 2019 and May and June 2021.[9] The letters patent appoint the Commissioners who are to conduct the inquiry and specify the terms of reference for the Royal Commission.

15. The Royal Commission's tenth public hearing was held in Sydney from 15 to 16 December 2020 before the Chair, the Honourable Roslyn Atkinson AO[10] and Ms Barbara Bennett PSM. It continued on 2 March 2021 with the addition of Dr Rhonda Galbally AC as the fourth commissioner.

16. Counsel Assisting the Royal Commission were Ms Kate Eastman SC and Ms Georgina Wright SC, instructed by the Office of the Solicitor Assisting the Royal Commission. A number of parties were granted leave to appear at the hearing. Those parties and their legal representatives are listed in **Appendix A.**

17. As set out in the Overview above, the public hearing examined the education and training of health professionals in the health care and treatment of people with cognitive disability.[11]

18. Before the hearing, Counsel Assisting and staff of the Royal Commission developed 11 propositions (Propositions) about the education and training of health professionals to provide a focus for inquiry at the public hearing. The Propositions were grouped into three main categories:

    - **Framework:** propositions about the development of a competency framework for cognitive disability health to guide the development of reforms to education and training in the health professions.
    - **Fundamentals:** propositions about the content and delivery of education and training in cognitive disability health to health professionals.
    - **Training phases:** propositions specific to stages of education and training.

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9 *Letters Patent* (Cth), 4 April 2019 amended 13 September 2019, 13 May and 24 June 2021. Each state government in Australia has also issued letters patent establishing the Royal Commission under state legislation. These letters patent are in substantially the same terms as those issued by the Australian Government and are available on the Royal Commission website.

10 The Honourable Roslyn Atkinson AO also participated but resigned her commission with effect from 24 June 2021. She has therefore played no part in preparation of this report.

11 Cognitive disability arises from the interaction between a person with cognitive impairment and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. 'Cognitive impairment' is an umbrella term to encompass actual or perceived differences in cognition, including concentration, processing, remembering, or communicating information.

19. The Propositions, which are at **Appendix B,** were tested at the hearing. Forty-three witnesses gave evidence, including twenty witnesses who provided written statements but did not give oral evidence. Witnesses gave evidence in panels that included representatives from education providers; accreditation authorities; national health profession boards; professional associations; medical colleges and peak bodies; expert researchers; health practitioners; and the Australian Government. We also heard from witnesses with lived experience of disability: Corey Burke, Toni Mitchell, Dr Dinesh Palipana and Laura Naing. Part 2 of this Report gives a summary of their evidence. A number of witnesses who gave expert evidence are also people with lived experience of disability.

20. There are practical difficulties in attempting to cover the experience of all health care professions in a single hearing on the education and training of health professionals in cognitive disability health. Consequently, the public hearing focussed on the education and training in medicine, nursing, dentistry, pharmacy, speech pathology and psychology. The education and training provided in these health disciplines is likely to reveal issues common to all health professions. While it was not possible to include witnesses from the full breadth of allied health professions, the evidence touched on the education and training of allied health professionals generally. Academics and advocates who gave evidence at the hearing (including from Allied Health Professions Australia) drew on experiences from a range of allied health professions.

21. A list of witnesses and panel compositions is at **Appendix C.**

22. In addition, 111 exhibits were tendered and admitted into evidence. Links to those exhibits, as well as to the transcripts of the public hearing and the Royal Commission's Terms of Reference, are at **Appendix D.**

Preparation of the Report

23. At the conclusion of Public hearing 10, the Chair directed Counsel Assisting to prepare written submissions (Counsel Assisting's Submissions) setting out the evidence relating to the Propositions examined at the public hearing and any proposed recommendations that may be made by the Royal Commission. Under the Chair's direction, Counsel Assisting's Submissions were made available on 7 April 2021 to parties who had leave to appear and to witnesses who gave evidence at the hearing. Responses to Counsel Assisting's Submissions were required by 7 May 2021.[12]

24. Written responses to Counsel Assisting's Submissions were received from 19 individuals and organisations. These included:

    - the Australian government

12 Transcript, Ronald Sackville (Chair), Public hearing 10, 2 March 2021, P-291 [45]–P-292 [11].

- several universities and medical colleges
- the Australian Medical Council (AMC)
- Medical Deans Australia and New Zealand (MDANZ)
- the Australian Nursing and Midwifery Accreditation Council (ANMAC)
- the Australian Pharmacy Council
- the Australian Psychological Society
- Speech Pathology Australia
- Allied Health Professions Australia
- the Professional Association of Nurses in Developmental Disability Australia Inc (PANDDA)
- a joint response from the Chairs of the Dental Board of Australia, Medical Board of Australia, Nursing and Midwifery Board of Australia, Pharmacy Board of Australia, and Psychology Board of Australia (National Board Chairs' joint response)
- Professor Julian Trollor and Dr Jane Tracy, who made submissions in their individual capacities.

25. Those responses (collectively referred to as Responses) together with Counsel Assisting's Submissions are published on the Royal Commission's website.

26. The Royal Commission also held a meeting with the AMC and MDANZ on 11 October 2021 to provide an opportunity for them to speak to their submissions.

27. Three of the four Commissioners who participated in the public hearing have contributed to this Report.[13] It has been prepared taking into account Counsel Assisting's Submissions and the Responses as well as the evidence given at the hearing. Commissioners Ms Andrea Mason OAM and the Honourable John Ryan AM read and commented on the draft Report.[14] The Commissioners responsible for the contents of the Report have taken those comments into account.

28. The Report does not provide a comprehensive account of the evidence presented in response to the Propositions. A detailed summary of individual witnesses' evidence is in Counsel Assisting's Submissions.

13 The Honourable Roslyn Atkinson AO also participated but resigned her commission with effect from 24 June 2021. She has therefore played no part in preparation of this report.

14 Commissioner Alastair McEwin AM very properly declared a potential conflict of interest in the subject matter of Public hearing 10 at the earliest possible time and has not been involved in the preparation of this Report, or consideration of issues addressed in the Report.

29. This Report begins with an Overview that presents the Commissioners' findings arising from Public hearing 10 and records the Commissioners' recommendations. It is then organised into six parts:

- Part 1 provides introductory comments and background to Public hearing 10.
- Part 2 summarises the evidence given at the public hearing about the proposition that a competency or similar framework for cognitive disability health education and training is needed. It also analyses the key issues about the development and implementation of the framework, including who should lead the work and be consulted; the scope of the framework; the timeframe for development and implementation; and funding issues.
- Part 3 addresses whether accreditation standards for health education programs should be amended to address cognitive disability health competencies.
- Part 4 considers clinical placements for students and trainees.
- Part 5 concerns post-graduate and continuing education and training.
- Part 6 addresses the need for a national centre of excellence in cognitive disability health.

30. There are five appendices to this Report:

- Appendix A: List of the parties granted leave to appear at the hearing and their legal representatives.
- Appendix B: Propositions developed by Counsel Assisting and staff of the Royal Commission before the public hearing.
- Appendix C: List of witnesses and panel compositions.
- Appendix D: Link to the exhibits tendered, the transcripts of the public hearing, and the Royal Commission's Terms of Reference.
- Appendix E: Acronyms and abbreviations used in this Report.

Status of the Report

31. The Commissioners have carefully considered the form this Commissioners' Report should take. It is important to publish the Report, including Findings and Recommendations, in a timely fashion. This will, we expect, guide and encourage prompt action by the representative bodies of the health professions and government agencies. We do not wish to delay the release of our Findings and Recommendations on these matters until the Royal Commission's Final Report is presented in approximately eighteen months. One reason for urgency is that the Findings and

Recommendations will inform current initiatives of the Australian Government, including the implementation of the *National Roadmap for Improving the Health of People with Intellectual Disability.*

32. We have decided to publish this as a Commissioners' Report, but not to present it to the Governor-General for tabling in Parliament as an Interim Report. Although the Report contains 'Findings' and 'Recommendations' we appreciate that they do not have the status of findings and recommendations in a formal report tabled in Parliament. An Interim Report would no doubt lend weight to the findings and recommendations, as the Australian Government would be obliged, in accordance with convention, to respond to the Recommendations. But this would involve additional consultations and formal processes, which would delay release of the Report.

33. The Report uses the expression 'Recommendations' rather than 'Proposed Recommendations'. We have adopted this terminology partly because we hope and expect the Recommendations to be acted upon promptly, but also because some Recommendations incorporate a reporting period of eight months. As that period will elapse before the Royal Commission's Final Report is completed, those Recommendations cannot be 'proposed' for the Final Report.

34. We are reassured by the strong commitment to reform demonstrated by the representatives of the Australian Government and the health professions who participated in Public hearing 10, and who responded so constructively to Counsel Assisting's Submissions.

35. As the Recommendations imply, we intend to monitor progress during the remaining term of the Royal Commission. We will determine what further action is required considering the responses to the Recommendations. The Royal Commission may include further findings and recommendations on this subject in the Final Report.

Part 2: Cognitive disability health capability framework

36. The Hearing Reports for Public hearing 4, Public hearing 5 and Public hearing 6 provide detailed accounts of the experiences of people with disability in the health system, as described by people with disability, their families and health professionals.[15] Witnesses at those hearings identified education and training as being critical to reducing the health inequities faced by people with cognitive disability. Professor Julian Trollor in particular drew attention to the lack of systematic training of medical and nursing students in the provision of health care or services to people with intellectual disability.[16]

37. Both 'cognitive disability' and 'intellectual disability' were referred to throughout the hearing and both terms were used in the evidence presented at the hearing.

38. A cognitive disability arises from the interaction between a person with cognitive impairment and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. The term includes not only people with intellectual disability, but other groups including, but not limited to, people with learning disability, dementia or acquired brain injuries, and some people with autism.[17] The term does not assume that the issues facing people identifying in each group are the same, nor should it be interpreted this way.

39. Professor Trollor's observations are supported by data obtained from audits of medical and nursing degrees conducted in 1995, 2014 and 2018. The audits found that:

    - Of 31 nursing schools that took part in the audit in 2014 (out of a total 34 accredited nursing schools), 16 (52 per cent) did not teach any intellectual disability content.
    - Only five out of 31 nursing schools (16 per cent) provided the opportunity for students to have direct contact with people with intellectual disability, such as during clinics or group home visits. Only one school involved a person with intellectual disability in delivering teaching content.[18]
    - Across eight medical schools audited in both 1995 and 2014, the number of relevant course units fell over the 20 years. The median number of hours of intellectual disability content provided by each school decreased.

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15 Those reports also refer to Australia's obligations to respect, protect and fulfil the rights of people with disability recognised in Article 25 of the *Convention on the Rights of Persons with Disabilities* 'to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability'.

16 Transcript, Professor Julian Trollor, Public hearing 6, 25 September 2020, P-342 [38-45].

17 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Interim Report,* October 2020, Glossary.

18 Exhibit 4-99, Trollor et al., 'Intellectual disability health content within nursing curriculum: An audit of what our future nurses are taught' (2016) 45 *Nurse Education Today,* pp 48-52.

- Of 14 medical schools that took part in the audit in 2014, the median time teaching compulsory disability content was 2.5 hours across the five to six-year programs. The majority offered less than six hours of compulsory teaching on intellectual disability content across the whole degree. The content was mostly taught in paediatrics, general practice and psychiatry courses.
- The backgrounds of educators and the methods used to teach the content varied considerably across medical schools. The extent to which people with intellectual disability were involved in designing and teaching content was also inconsistent.[19]

40. The results of the audits are consistent with other research summarised in Counsel Assisting's Submissions. The research identified a lack of training of medical and other health professionals in intellectual disability health care at all stages from primary degree level to specialist training.[20] Medical professionals have reported they lack the knowledge, skills and confidence to work with people with intellectual disability and would like enhanced education.[21] This lack of systematic training in cognitive disability health extends to the dental profession.[22]

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19 Exhibit 10-64, Trollor, Eagleson, Ruffell, Tracy et al, 'Has teaching about intellectual disability healthcare in Australian medical schools improved? A 20-year comparison of curricula audits', (2020) 20 *BMC Medical Education,* p 231; Exhibit 4-57, Julian Trollor et al., 'Intellectual disability health content within medical curriculum: an audit of what our future doctors are taught', (2016) 16(1) *BMC Medical Education;* Exhibit 4-53, J Trollor et al., 'Intellectual disability content within tertiary medical curriculum: How is it taught and by whom?' (2018) 18(182) *BMC Medical Education,* pp 1-10.

20 Exhibit 4-58, J. Trollor, C. Eagleson, B Turner, C Salomon, A Cashin et al, 'Intellectual Disability content within pre-registration nursing curriculum: How is it taught?' (2018) 69 *Nurse Education Today,* 49; Exhibit 4-99, Julian Trollor et al., 'Intellectual disability health content within nursing curriculum: An audit of what our future nurses are taught' (2016) 45 *Nurse Education Today,* p 75; Exhibit 10-69, Cahley Hemm, Dave Dagnan & Thomas Meyer, 'Identifying Training Needs for Mainstream Healthcare Professionals, to Prepare Them for Working with Individuals with Intellectual Disabilities: A Systematic Review' (2014) 28(2) *Journal of applied research in intellectual disabilities,* p 23.

21 Exhibit 4-54, Trollor, Eagleson, Turner, Tracy et al, 'Intellectual disability content within tertiary medical curriculum: how is it taught and by whom?' (2018) 18(182) *BMC Medical Education,* pp 1-10; Exhibit 10-74, Jane Tracy and Rachael McDonald, 'Health and disability: partnerships in health care', (2014) 28 *Journal of Applied Research in Intellectual Disabilities,* pp 22-32.

22 Exhibit 10-72, Kangutkar, Watson, & Calache, 'Education and training interventions that focus on improving oral health related well-being of people with intellectual disability: A review report', (2020) 41(2) *Intellectual Disability Australasia,* pp 24-27; Exhibit 10-71, M. Ahmad et al., 'Undergraduate Education in Special Needs Dentistry in Malaysian and Australian Dental Schools', (2014) 78(8) *Journal of Dental Education,* p 1154; Exhibit 10-65, A. Dougall et al., 'Developing an undergraduate curriculum in Special Care Dentistry – by consensus' (2012) 17(1) *European Journal of Dental Education*, p 46.

41. In preparation for Public hearing 10, the Royal Commission sought information from a number of universities and medical colleges about their curriculum content on cognitive disability health in health practitioner programs. These included seven universities: University of Sydney; University of New South Wales (UNSW); University of Queensland; University of Tasmania; University of Western Australia; Monash University; and Flinders University. Information was also sought from the following medical colleges: Royal Australian and New Zealand College of Psychiatrists (RANZCP); Royal Australasian College of Physicians (RACP); Royal Australian College of General Practitioners (RACGP); Australian and New Zealand College of Anaesthetists (ANZCA); Australasian College of Emergency Medicine (ACEM); and Australian College of Rural and Remote Medicine (ACRRM). Each education provider identified elements in its curriculum about intellectual and/or cognitive disability and relevant forms of assessment.

42. Based on the information obtained by the Royal Commission and the publicly available academic literature and research, we are satisfied that cognitive disability health is not systematically taught in health practitioner programs. Further, the extent to which education providers teach cognitive disability health content varies considerably when comparing similar degree types. Students in health disciplines are not required to develop specific competencies in cognitive disability health. As a result, students in the same discipline have different levels of exposure to cognitive disability health issues. We are also satisfied that enhancing education and training in cognitive disability health is an available and critical strategy for mitigating the health inequities experienced by people with cognitive disability. We make these findings (Findings 1, 2 and 3).

Finding 1

Education providers of entry-level health practitioner programs do not adopt a consistent approach to teaching about the health care of people with cognitive disability (cognitive disability health). Education providers in a given health discipline vary considerably in how much they teach cognitive disability health content.

Finding 2

Education providers of health practitioner or postgraduate medical programs are not currently required to deliver education or training about specific competencies or capabilities in cognitive disability health. Because of this, students and trainees have variable exposure to cognitive disability health issues. A capability or similar framework developed across health professions would assist education providers to develop or enhance their education and training programs so that future practitioners, including specialists, develop appropriate skills in cognitive disability health.

Finding 3

1. The development of a cognitive disability health capability or similar framework is an available and critical strategy to ensure that cognitive disability competencies, curricula content and resources are developed across health practitioner programs at entry-level and postgraduate level and as part of in-service training and continuing professional development (CPD).
2. Successful development and implementation of a cognitive disability health capability framework (capability framework) requires leadership of the education, regulatory and professional bodies responsible for the education and training of health professionals. It also requires that people with lived experience of cognitive disability co-design the framework. Those leading the process will need to take responsibility for consultation with bodies responsible for education and training across health professions and for implementing an effective co-design process.
3. We are satisfied that the Australian Medical Council and the Medical Deans Australia and New Zealand have the necessary skills, expertise, commitment and established networks with the other stakeholders to assume this role and lead this inter-disciplinary work.
4. The steering committee that is established to progress the framework should include bodies and people who:
    a. have lived experience of cognitive disability
    b. have a demonstrated capacity to partner with people with lived experience of cognitive disability
    c. have experience in developing and implementing competency or similar frameworks
    d. have clinical skills in cognitive disability health recognised by peers
    e. represent the continuum of health practitioner education and training, including entry-level and postgraduate programs, in-service training and CPD
    f. will be responsible for implementation of the framework in educational and health care settings.

43. It is important to note that the focus in this Report on health professional education and training is not intended to perpetuate a medical model of disability in the health care of people with cognitive disability. Rather, we are seeking to continue the shift away from that model in health care practices. As stated in Counsel Assisting's Submissions,[23] the Royal Commission discussed its position on disability theory and models in its Interim Report.[24] Disability theorists have critiqued the medical model of disability that has greatly influenced the approach of the medical profession and the health system towards people with disability. They argue that this model conceptualises disability as an individual defect to be eliminated, cured or hidden away.[25] It can generate paternalism and pity, and it can create social environments that are conducive to discrimination, exclusion, violence and neglect.[26]

44. Our focus on the health workforce is intended to drive measures that can and should be taken now to help address the Royal Commission's finding that people with cognitive disability have been, and continue to be, subject to systemic neglect in the Australian health system.[27] The evidence we have heard has highlighted the need to better equip health practitioners to provide the safe and high quality health care that people with cognitive disability need just like any other member of the community. This includes being able to address the often complex health needs of people with cognitive disability who may have co-morbidities and/or communication difficulties associated with the disability. It also includes addressing the attitudes and values held by health professionals that reflect unconscious or inherent bias towards people with disability and obstruct their access to health care.

45. Proposition 1 tested by Counsel Assisting at Public hearing 10 was that a competency or similar framework for health professionals should be developed promptly through consultation between people with disability, stakeholders in the higher education system, health professionals and accreditation bodies. The framework should specify the core knowledge, skills and attributes required by health professionals to equip them to provide quality health care to people with cognitive disability.

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23 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Counsel Assisting submissions on Public hearing 10*, October 2020, [145].

24 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Interim Report,* October 2020, p 345.

25 Shane Clifton, *Hierarchies of power: Disability theories and models and their implications for violence against, and abuse, neglect, and exploitation of people with disability,* Research report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, October 2020, 15.

26 Bill Hughes, 'Fear, pity and disgust' in *Routledge handbook of disability studies,* Routledge, 2012, 68.

27 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 4: Health care and services for people with cognitive disability,* February 2020, pp 139-140 [488].

46. The witnesses and bodies involved in Public hearing 10 supported the development of a competency framework for cognitive disability health. They agreed the framework should set out the knowledge, skills and professional attributes required by health professionals treating people with cognitive disabilities, which should be taught in health practitioner programs.

47. Education providers emphasised their autonomy in the design, development and content of their programs. However, they also acknowledged their responsibility for ensuring graduates and trainees develop appropriate skills and knowledge necessary to work competently with patients with cognitive disabilities. Across the panels the witnesses from universities expressed the view that a common set of capabilities and resources, developed collectively, would support them in this role. Medical colleges also expressed support for the usefulness of a framework. Witnesses recognised the potential to improve skills and reduce health inequities through enhancing cognitive disability health curricula in education and training programs.

48. Witnesses with lived experience of cognitive disability gave evidence about their experiences in the health system as patients, health professionals, trainers and parents and carers:

- Laura Naing works for the Council for Intellectual Disability on developing training resources that focus on communication, attitudes and treatment for people with disability. She said she knows how doctors treat her and can therefore help to train and educate them to help other patients with cognitive disability. Her work also aims to assist people from culturally and linguistically diverse backgrounds to improve their health awareness and access health services.[28]
- Corey Burke is working on a project to train nurses to have a better understanding of people with 'special needs'.[29] He also participates in a group where he discusses his experiences accessing health care and his views about what nurses should know when caring for people with cognitive disability.[30]
- Dr Dinesh Palipana is a medical practitioner in the accident and emergency department of a public hospital in Queensland. He is a disability advocate and has quadriplegia and gave evidence in his personal capacity. He said his undergraduate medical education involved minimal learning about the health care needs of people with cognitive disability.[31] While he recalled content about the medical aspects of conditions such as Down syndrome, he said there was minimal specific training around caring for patients with disabilities. Dr Palipana emphasised the importance of junior doctors having appropriate skills to communicate with patients with disability given 'they are

28 Transcript, Laura Naing, Public Hearing 10, 16 December 2020, P-147.

29 Transcript, Corey Burke, Public Hearing 4, 15 December 2020, P-38.

30 Transcript, Corey Burke, Public Hearing 4, 15 December 2020, P-38.

31 Transcript, Dr Dinesh Palipana, Public Hearing 10, 15 December 2020, P-69 [15-23].

the workforce that manages and faces the patients the most'. He said that this is particularly important in rural areas.[32] He supported the Propositions.

- Toni Mitchell has delivered classes to medical registrars at Toowoomba Hospital about Down syndrome for over five years. Her son Joshy delivers the training with her. They train the registrars to see past Joshy's Down syndrome to his underlying medical issues.[33]

49. Counsel Assisting's Submissions contain a detailed summary of the views of the witnesses and entities who participated in Public hearing 10 and other evidence supporting the need for a competency framework.[34] We do not repeat that summary in this Report. Public hearing 4, Public hearing 5 and Public hearing 6 also heard evidence about the need for health professionals to receive better education about the inequities in health outcomes and the barriers to care that people with cognitive disabilities experience. This evidence is summarised in previous Hearing Reports.

50. Based on this evidence, we are satisfied that there is both a need and broad support for development of a competency or similar framework to assist health education providers to incorporate and enhance curriculum content about the provision of health care to people with intellectual and other cognitive disability.

51. Counsel Assisting referred to the proposed framework as setting out required competencies.[35] However, several witnesses said that 'capabilities' is the appropriate terminology for describing the values, knowledge, skills and understanding that are developed over time and used by health professionals in disparate contexts.[36] It is a broader notion than competency. Whether the framework is referred to as a competency or capability framework will be a matter for those who develop the framework. In this Report we refer to it as a 'capability framework', 'cognitive disability health capability framework' or simply 'the framework'.

52. Frameworks of this kind are widely used in various contexts to describe professional or teaching standards and the knowledge, behaviour and capabilities required or valued in a particular profession. Accreditation authorities have developed profession-specific competency frameworks under the National Registration and Accreditation Scheme for health practitioners (the National Scheme), which is established under the *Health Practitioner Regulation National Law.*[37]

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32 Transcript, Dr Dinesh Palipana, Public Hearing 10, 15 December 2020, P-77 [40-45] and [87-88].

33 Transcript, Toni Mitchell, Public Hearing 10, 16 December 2020, P-96 [24-47], P-97 [1-7].

34 Submissions of Counsel Assisting, Public hearing 10, 3 May 2021, DRC.9999.0072.0133, pp 12-28.

35 Transcript, Georgina Wright (Counsel Assisting), Public hearing 10, 15 December 2021, P-20 [39-46].

36 See for example, Transcript, Professor Rosalind Bull, Public hearing 10, 15 December 2021, P-28 [11-18].

37 For an explanation of the origins and operation of the *Health Practitioner Regulation National Law,* see Report, [114].

53. However, the capability framework would be broader in scope and more detailed than competency frameworks developed under the National Scheme. As noted by witnesses at the public hearing, the capability framework would apply across registered and non-registered health professions and be relevant to multiple stages of education and training, including entry level, post-graduate, in-service training and CPD. Some submissions suggested the framework should adopt a tiered approach in addressing the skills, knowledge and professional attributes required in cognitive disability health. A tiered approach would reflect the different levels of service provider, work contexts and competencies required in caring for and treating people with cognitive disability.[38] We return to this issue below.

54. Several witnesses also expressed strong support for developing shared learning resources for use by education providers, at the same time as developing the framework. The witnesses representing universities emphasised that 'a common set of multi professionally relevant model learning resources' that are freely available and of high quality would be very valuable to them.[39] They said this could include clinical case studies and model curriculum. The National Roadmap includes short and medium-term actions directed to the development of tools and resources to support curriculum development in intellectual disability health in education, training and CPD programs for health professionals.[40]

55. We note PANDDA's objection to the broad categorisation of 'cognitive disability', which they suggest risks further marginalising people with intellectual disability.[41] This is an important issue which we address below.

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38 Submission of Speech Pathology Australia, Public hearing 10, 10 June 2021, SUBM.0010.0014.0001, p 1; Submission of Allied Health Professions Australia, Public hearing 10, June 2021, SUBM.0010.0003.0001, p 3; Submission of Professor Julian Trollor, Public hearing 10, SUBM.0010.0008.0118, p 4.

39 Transcript, Professor Rosalind Bull, Public Hearing 10, 15 December 2020, P-17; Professor Richard Murray, Transcript of meeting with AMC and MDANZ, p 9; Exhibit 4-9, 'Statement of Professor Julian Trollor', 11 February 2020, [254]; Transcript, Professor Michelle Leech, Public Hearing 10, 15 December 2020, P-26; Transcript, Professor Gary Velan, Public Hearing 10, 15 December 2020, P-32-3; Transcript, Bronwyn Clark, Public Hearing 10, 2 March 2021, P-234; Transcript, Professor Richard Murray, Public Hearing 10, 15 December 2020, P-84, P-87; Exhibit 10-8, 'Statement of Associate Professor Mark Lane', 14 February 2020, 15; Transcript, Professor Inam Haq, Public Hearing 10, 15 December 2020, P-87 [10-17].

40 *National Roadmap for Improving the Health of People with Intellectual Disability, Australian Government,* July 2021, pp 19-20; Exhibit 10-102.1, 'Curriculum Development in Health Care for People with Intellectual Disability – Final summary', 16 December 2020.

41 Submission of Professional Association of Nurses in Developmental Disability Australia Inc, Public hearing 10, SUBM.0010.0011.0001.

Models for a cognitive disability health capability framework

56. Counsel Assisting referred to two existing frameworks as being particularly relevant and helpful for considering a cross-profession framework for cognitive disability health: the *Aboriginal and Torres Strait Islander Health Curriculum Framework and the Intellectual Disability Mental Health Core Competency Framework.*

57. The *Aboriginal and Torres Strait Islander Health Curriculum Framework* (ATSI Framework) was developed to address the variability among higher education providers in the extent to which Aboriginal and Torres Strait Islander health curriculum was being implemented.[42] The stated aim was to provide a model for education providers to implement Aboriginal and Torres Strait Islander curricula, with clear learning outcomes and associated capabilities that could be applied widely across tertiary learning contexts. Disparities in health between Aboriginal and Torres Strait Islander and other Australians are well documented, and several health disciplines have already commenced incorporating such content, including medical, nursing, psychology and occupational therapy disciplines.[43]

58. That framework provided a 'map' to assist higher education providers to implement Aboriginal and Torres Strait Islander health curricula. It also set out criteria that accreditation authorities could adopt in their accreditation standards.

59. It is relevant to note that accreditation standards across regulated health professions were amended following development of that framework, resulting in broad adoption of its contents. Whether that would have occurred without those amendments is an open question. Academics who gave evidence at Public hearing 10 spoke about the process of embedding that content into their educational programs as a consequence of the accreditation standards being amended, despite the curricula already being crowded. They agreed that a national capability framework addressing cognitive disability health would require a similar process and be a similarly valuable exercise.[44]

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42 Exhibit 10-79, 'Australian Government Department of Health, Aboriginal and Torres Strait Islander Health Curriculum Framework', 26 February 2016.

43 The Framework was developed in response to the *Growing Our Future: Final Report of the Aboriginal and Torres Strait Islander Health Worker project* in 2011 by Health Workforce Australia which recommended that mandatory cultural competency curricula be embedded in vocational and tertiary education for health professionals. Exhibit 10-79, 'Australian Government Department of Health, Aboriginal and Torres Strait Islander Health Curriculum Framework', 26 February 2016, pp 1-8.

44 For example, Transcript, Professor Michelle Leech, Public Hearing 10, 15 December 2020, P-32; Transcript, Professor Gary Velan, Public Hearing 10, 15 December 2020, P-30; Transcript, Dr Jane Tracy, Public Hearing 10, 15 December 2020, P-33.

60. Ms Theanne Walters, Deputy Chief Executive Officer of the AMC, said that, while competency framework documents are taken up by medical schools in different ways, the development of the framework proposed would be very valuable. She commented that there was as much value in the process of developing the A*boriginal and Torres Strait Islander Health Curriculum Framework,* and the resources made available for medical schools to apply it to their course as the final product.[45]

61. Given the breadth of the ATSI Framework and its implementation across health professions, we agree that it is likely to be helpful for those who develop the cognitive disability health framework to draw on the experience gained from that process.

62. Counsel Assisting also highlighted as a model framework the *Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals* (Manual). The UNSW Department of Developmental Disability Neuropsychiatry developed the Manual for the New South Wales mental health workforce. The Manual describes the specific skills and attributes required by mental health professionals to provide quality services to people with an intellectual disability. That framework is likely to contain competencies appropriate for inclusion in the cognitive disability health framework, as Counsel Assisting suggested.

63. The Manual was produced after a broad consultation process. It was endorsed as codifying best practice for mental health professionals treating patients with intellectual disability. Even so, the Manual has not been generally adopted.

64. During Public hearing 10, Professor Trollor used the Manual to illustrate his concern that developing a competency framework will not suffice to ensure that an intellectual disability framework is implemented and actually used.[46] He favours mandating the content of curricula through the amendment of accreditation standards.

Who should lead development of the framework?

65. Leadership in the development of a cognitive disability health capability framework is clearly needed.

66. Counsel Assisting submitted that the peak bodies for medical, nursing and dental education should take a leadership role and establish a working group to develop the framework. Further, those peak bodies should consult with relevant organisations and persons to establish such a working group, including the Australian Health Practitioner Regulation Agency (AHPRA), National Boards, relevant professional associations, and people with cognitive disability.

45 Transcript, Theanne Walters, Public Hearing 10, 15 December 2020, P-86 [34] – P87 [6].

46 Transcript, Professor Julian Trollor, Public Hearing 10, 16 December 2020, P-173.

67. One submission expressed concern that this proposal might lead to two groups being formed and result in a power differential and potential lack of engagement from some organisations.[47] We accept there should not be 'two groups'. However, practically speaking, leadership is required to bring all necessary stakeholders together and coordinate the work.

68. In its response to the Royal Commission, MDANZ indicated its willingness to lead the work. It said it had secured agreement to collaborate from the peak bodies representing nursing and dental practitioner education, the Council of Deans of Nursing and Midwifery, and the Australasian Council of Dental Schools. MDANZ said a substantial piece of work is required to engage and consult with the broad range of stakeholders to develop the capability framework, including the large number of universities offering health practitioner programs. As well, associated resources and strategies would be needed to enable and support the uptake of the framework within curricula.

69. Accreditation authorities submitted that they should comprise or be included in any working group leading the design of the framework given their experience and role in developing competency standards under the National Scheme. The National Board Chairs' joint response proposes that an entity or group with content expertise should lead development of the framework with or in consultation with the accreditation authorities. They support wide consultation regardless of which peak bodies take the lead role, consistent with AHPRA's consultation requirements when developing accreditation standards. The National Boards do not seek to lead the work because the proposed framework will be broader than competency frameworks generally developed under the National Scheme.[48]

70. The AMC submitted that the accreditation authorities should join with the peak education bodies in leading the design of the framework. This would assist the work to align the framework with accreditation standards and practices. The AMC's experience in the development of competency/capability frameworks includes both cross-profession frameworks and medical profession specific frameworks.[49]

71. RACP indicated that it would like to play an active role in developing the capability framework. This is due to the significant role that RACP members have in providing health care to people with cognitive disability as well as the benefits that representation across the continuum of medical training would give to such a framework. RACP said the body that leads development of the framework should be sufficiently representative and skilled in undertaking work of this nature. It should also include people with demonstrated capacity to partner with people with lived experience of cognitive disability[50].

47 Submission of Professor Julian Trollor, Public hearing 10, SUBM.0010.0008.0118, p 5.

48 Submission of AHPRA National Board Chairs, Public hearing 10, 14 June 2021, SUBM.0010.0010.0001, p 4.

49 Submission of Australian Medical Council, Public hearing 10, SUBM.0010.0019.0001, pp 1-2.

50 Submission of Royal Australian College of Physicians, Public hearing 10, 7 June 2021, SUBM.0010.0012.0001, p 2.

72. All witnesses and bodies that participated in Public hearing 10 recognised that people with disability and their families and carers must be given genuine opportunities to contribute to the development of the framework through the contribution of their lived experience in health care systems. This is clearly essential.

73. The AMC advised that developing the capability framework will require dedicated additional resources, including for collating resources, drafting documents and managing the consultation process, including forums for stakeholder engagement.[51] The Australian Psychological Society (APS) also emphasised the need for external funding.[52]

74. The Australian Government submitted that the Australian Government Department of Health is best placed to oversee development of the framework and convene the working group given the Department's work on the *National Roadmap for improving the health of Australians with intellectual disability*.[53] We address the relationship between this work and our recommendations below.

75. We accept that the Australian Government Department of Health has an important role to play in facilitating development of the capability framework. However, in our view primary responsibility for developing and implementing the framework should rest with the professional and regulatory bodies themselves. This conclusion is consistent with the Australian Government Department of Health playing an active role, for example, by providing secretariat support for the steering committee[54] that will oversee the process. However, the leadership role in the design of the framework and associated resources should be taken by those who are responsible for setting and implementing educational standards and curricula. We make a finding to this effect (Finding 3).

76. The concept of stewardship by the stakeholders is important. Those leading the process will need to take responsibility for an effective co-design process with people with lived experience of cognitive disability, and for comprehensive consultation between all of the bodies responsible for education and training across health professions.

77. Counsel Assisting proposed an alternative recommendation, namely that the Royal Commission convene a working group to develop the framework.[55] We do not adopt that proposal because of our finding that a leadership role by the education, regulatory and professional bodies is critical to the success of the framework's development and implementation. These bodies will continue to exist beyond the Royal Commission and

51 Submission of Australian Medical Council, Public hearing 10, 8 July 2021, SUBM.0010.0019.0001, p 2.

52 Submission of Australian Psychological Society, Public hearing 10, 11 June 2021, SUBM.0010.0006.0001, p 4.

53 Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, p 7.

54 We will use the expression 'steering committee' for convenience. Other descriptions would be equally appropriate.

55 Submission of Counsel Assisting, Public hearing 10, 3 May 2021, DRC.9999.0072.0133, p 5 [10].

are best placed to ensure the framework is implemented and reviewed in the longer term. This does not, however, preclude the possibility that the Royal Commission might assist in the early stages if assistance is requested.

78. In our assessment, the best way forward is for the AMC and MDANZ jointly to establish a steering committee to develop the capability framework, including core curriculum resources, and to plan for its implementation. We are satisfied that both organisations have the necessary commitment, skills, expertise and established networks with the other stakeholders to assume this role and lead this inter-disciplinary work. We make a finding to this effect (Finding 3).

79. It is critically important that the composition of the steering committee and the committee consultation processes are acceptable to the disparate bodies and people who will later use and benefit from the framework. This includes people with cognitive disability. In her submission, Dr Jane Tracy of the Centre for Developmental Disability Health Victoria advised:

> The Roundtable [for the National Roadmap process] was an excellent example of inclusive, collaborative practice. The experiences and views of people with cognitive impairment were always central to the meetings, and the use of videoconferencing meant that stakeholders from all parts of the country and with a range of abilities had the opportunity to participate and contribute.[56]

80. The development of a capability framework is likely to require work in multiple stages and the use of various methodologies (like the ATSI framework development process). We consider the roundtable approach would have much to contribute as a means of achieving a consensus in the process.

81. We make the finding (Finding 3) that the bodies and people who are represented on the committee or group should:

- include people with lived experience of cognitive disability
- have a demonstrated capacity to partner with people with lived experience of cognitive disability
- have experience in developing competency or similar frameworks
- have clinical skills in cognitive disability health recognised by peers
- adequately represent the continuum of health professional education and training, including entry-level and postgraduate programs and CPD
- include bodies that will be tasked with requiring or supporting implementation of the framework in educational and health care settings.

56 Submission of Dr Jane Tracy, Public hearing 10, SUBM.0010.0007.0001, p 2.

82. We anticipate that bodies and people meeting these criteria will include:

- peak bodies representing medical, nursing, dental, pharmacy and allied health professional education, and universities and medical colleges
- clinical experts
- accreditation authorities
- health professional regulatory bodies, boards and councils (which include AHPRA and relevant National Boards)
- advocacy groups representing people with cognitive disability
- people with cognitive disability
- family members and carers of people with cognitive disability.

Scope of the capability framework

83. Issues were raised at the public hearing about the scope of the proposed capability or similar framework, including:

- whether it should be limited to the health needs of people with cognitive disability
- which health professions should be covered by the framework
- to which levels of education it would apply
- how detailed the framework should be.

84. We have considered each of these issues in turn.

Cognitive disability health

85. As noted earlier in this Report, 'cognitive disability' is an umbrella term that includes actual or perceived differences in cognition.[57] This includes, but is not limited to, intellectual disability. Specific issues affecting people with intellectual disability must be properly addressed in the capability or similar framework that is developed.

86. This issue underscores the need for participation by people with intellectual disability, organisations that represent them and clinical experts in the process of developing and implementing the framework. Involving bodies with significant expertise in intellectual disability health and knowledge of the experience of people with intellectual disability in the health system will be important. Examples of such bodies are the Department of Developmental Disability Neuropsychiatry at UNSW, the Centre for Developmental Disability Health Victoria and the Council for Intellectual Disability.

57 See Report, [38].

87. Provided that the steering committee developing the capability framework is sufficiently representative and skilled and consults widely, we consider that the framework will ensure that health professionals acquire improved understanding of the experiences and health needs of people with cognitive disability.

Applicable health professions

88. The National Board Chairs submitted that the framework could apply across all health professions regulated under the National Scheme.[58] However, they acknowledged that some of the proposed reforms relate also to unregulated non-registered health professions, such as speech pathology. The National Board Chairs said that, if the Royal Commission makes recommendations relevant to both registered and non-registered health professions, there should be no barrier to collaboration between health professions, whether or not they fall under the National Scheme.

89. The National Scheme was established by state and territory governments for health practitioners in 2010 and covers the health workforce across Australia. The National Scheme currently covers 15 professions: Aboriginal and Torres Strait Islander health practitioners; Chinese medicine practitioners; chiropractors; dental practitioners; medical radiation practitioners; medical practitioners; nurses and midwives; occupational therapists; optometrists; osteopaths; paramedics; pharmacists; physiotherapists; podiatrists; and psychologists. They are referred to as registered or regulated health professions.

90. Each profession has a national board which regulates the profession, registers practitioners and develops standards, codes and guidelines for the profession. AHPRA administers the National Scheme and provides administrative support to the national boards.

91. Health professions that are not regulated under the National Scheme are still subject to a range of laws and codes of conduct that regulate their practice. Some have self-regulatory arrangements operated by their peak professional bodies. These provide similar functions to AHPRA, including setting and maintaining accreditation standards and overseeing professional development. Accreditation by the peak body is generally required by Medicare, the National Disability Insurance Scheme and private health insurers. Speech pathologists, dieticians, audiologists and rehabilitation counsellors are some of the non-registered allied health professions.

58 Submission of AHPRA National Board Chairs, Public hearing 10, 14 June 2021, SUBM.0010.0010.0001, p 5.

92. Several submissions argued that the capability framework should cover all relevant allied health professions.[59] We agree with this. The framework should not be limited to the six health professions whose representatives gave evidence at Public hearing 10. As noted, those six professions were selected so that issues could be explored that are likely to reflect issues arising in other health disciplines. The framework should apply to both registered and non-registered health professions that provide health care to people with cognitive disabilities.

Content of a cognitive disability health framework

93. Accreditation authorities (AMC and ADC) suggested to the Royal Commission that a framework applying across health professions would describe capabilities at a high level to incorporate issues common to the professions. In addition to these core capabilities that apply across all professions, the capability framework should be supplemented by evidence, guidance and requirements for education and training for specific professions to recognise the distinct role performed by each profession.[60] We agree with this important observation.

94. The Australian Government also noted that aspects of core knowledge, skills and attributes are likely to be profession-specific, necessitating additions or variations to the capability framework.[61] Its submission pointed out that health practitioners who are in practice will not benefit from education and training strategies targeted at entry-level curriculum, and that the approach to development of the framework will need to encompass post-qualification education. This is consistent with Counsel Assisting's Submissions.

95. Allied Health Professions Australia suggested that the capability framework should not only address capabilities that are common to all service providers. As well, it should cater for different competency levels for different work contexts, because some professions work more consistently with people with cognitive disabilities than others.[62]

96. We accept all of these submissions. The capability framework should be as comprehensive as practicable. It should apply not only to entry-level training and curricula, but also to post-qualification education, particularly for specialist medical

59 Submission of Australian Pharmacy Council, Public hearing 10, 11 June 2021, SUBM.0010.0005.0001, p 2; Submission of Allied Health Professions Australia, Public hearing 10, June 2021, SUBM.0010.0003.0001, p 2; Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, at p 8; Submission of Professor Julian Trollor, Public hearing 10, SUBM.0010.0008.0118, p 6; Submission of Speech Pathology, Public hearing 10, 10 June 2021, SUBM.0010.0014.0001, p 1.

60 Submission of Australian Medical Council, Public hearing 10, 8 July 2021, SUBM.0010.0019.0001, p 2; Australian Dental Council, Submission, SUBM.0010.0002.0001, p 12.

61 Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, p 8.

62 Submission of Allied Health Professions Australia, Public hearing 10, June 2021, SUBM.0010.0003.0001, p 3.

professions (including general practice). The framework should meet the requirements of multiple professions, and do so separately to the extent necessary. Accordingly, the framework should include different competency levels, depending on the centrality of professional groups to the health care of people with cognitive disabilities. This may require a tiered approach to describing capabilities.

97. Counsel Assisting's Submissions also outlined particular areas requiring attention, including (but not limited to) bias, communication knowledge and skills, reasonable adjustments and interprofessional practice. The Submissions and the Royal Commission's Report for Public hearing 4 highlight the importance of interprofessional practice and integrated care for people with cognitive disability. We make a finding in this Report about its importance in future curriculum development (Finding 4).[63] The framework should be attentive to this and the other areas mentioned above. Including experts in cognitive disability health in the leadership structure will ensure these areas are covered.

Finding 4

Curriculum development relating to cognitive disability health must include skills in interprofessional practice and integrated care.

98. We accept Counsel Assisting's Submissions that the framework should:

- cover the core aptitudes required for health professionals to care for people with cognitive disability, including specifically intellectual disability
- pay particular attention to areas of need, including communication knowledge and skills; attitudes and values; reasonable adjustments; and interprofessional practice
- address the impacts of the health care system and health service delivery for people with cognitive disabilities, including the barriers to quality health care they face
- address both profession-specific and common standards or capabilities
- tier the level of capabilities and development of curriculum to levels of education and training
- support education providers to determine whether they have the minimum level of content required in health programs

63 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 4: Health Care and Services for People with Cognitive Disability,* October 2020, [139], [160], [246]-[247], [252], [482].

- align the content to learning outcomes without stipulating the precise methods of teaching pedagogy or content
- provide resources, tools and guidelines to assist education providers and curriculum designers to implement the framework and to assess students.

99. The Royal Commission heard in Public hearing 6 that education and training are central to addressing the over-use and misuse of psychotropic medication to treat 'behaviours of concern' by people with cognitive disability. The Hearing Report noted that health and disability professionals need greater skills and expertise to:[64]

- address attitudes, assumptions or beliefs that behaviours of concern are the fault of the person with cognitive disability or the product of an unalterable inherent condition
- recognise and address underlying causes of behaviours of concern, rather than focusing on the behaviours themselves
- enhance methods of communication to ensure that informed consent to the use of psychotropic medication is given wherever possible
- recognise and implement positive behaviour support as an alternative to psychotropic medication.

100. The capability framework should also pay attention to these issues.

Resourcing to develop the framework

101. We are mindful of the overlap between the Australian Government's *National Roadmap on Improving the Health of People with Intellectual Disability* and the Royal Commission's work. The Australian Government finalised the *National Roadmap* in July 2021, after Public hearing 10 was completed. The Australian Government committed $4.7 million to curriculum development in intellectual disability health as one of the short-term actions (one to three year) in the National Roadmap.[65]

102. It is obviously desirable that initiatives directed to curriculum development to improve health services for people with disability should not involve duplication of effort. The curriculum development initiative contained in the National Roadmap does not expressly contemplate the introduction of a capability framework. Moreover, unlike the proposed capability framework, the National Roadmap initiative is directed to entry-level (university level) education.

64 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 6: Psychotropic medication, behaviour support and behaviours of concern,* June 2021, [331]-[332].

65 Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, at p 3.

103. The proposed capability framework is broader in scope. It can, and should be, designed to inculcate the knowledge, skills and attributes required of trainees in specialist training programs. As noted earlier, the Colleges that participated in Public hearing 10 agreed that a capability framework in cognitive disability health would be relevant to their programs. We also agree based on our review of the course content.

104. The proposed capability framework would assist the Colleges to benchmark their existing programs and ensure they provide adequate training for future specialists to develop appropriate skills in cognitive disability health. There should also be career pathways available for those interested in subspecialty training. The capability framework will contribute to promoting this aim.

105. The National Roadmap initiative and the proposed framework have similar objectives. The funds the Australian Government has committed to the National Roadmap's curriculum development initiative could contribute to implementing the capability framework proposed in this Report, at least to the extent that the initiative and proposed framework overlap. In any event, funding from the Australian Government is likely to be required to expand the scope of consultation needed to develop a framework that applies to post-graduate training.

Approach to translating the capability framework into curricula

106. Education providers already incorporate to varying degrees cognitive disability health content in their programs. They adopt different approaches to imparting the knowledge, skills and attributes to undergraduates and practitioners. It is essential that they retain the freedom to innovate and to adapt their programs to the specific requirements of their health profession.

107. For these reasons, with one exception, we do not make recommendations about the specific content of the cognitive disability health content of the curricula for the various health professions. As Counsel Assisting's Submissions pointed out, the academic literature recommends the use of different methods to teach cognitive disability health content.[66] The one exception is that the curriculum for each health profession should involve people with cognitive disability. This is a powerful and effective means of changing the perceptions and attitudes of participants in education programs.[67]

108. While we do not propose to be prescriptive about the content of curricula, we consider that the steering committee should develop a detailed implementation plan outlining the key steps to translate the capability framework into the curriculum of each health

66 Submissions of Counsel Assisting, Public hearing 10, 3 May 2021, DRC.9999.0072.0133, [118]-[199].

67 Exhibit 4-54, Trollor, Eagleson, Turner, Tracy et al, 'Intellectual disability content within tertiary medical curriculum: how is it taught and by whom?', (2018) 18(182) *BMC Medical Education,* pp 1-10.

profession. An implementation plan is essential to provide guidance to education providers and encourage consistency among providers. It should provide momentum for change in the education programs of the health profession. We address these matters in Recommendation 1.

109. The implementation plan will need to develop, or oversee the development of, a core set of resources that can be shared across educational providers and institutions and be used in healthcare settings. The plan should specify the key steps necessary to ensure effective implementation of the capability framework by the diverse health professions. For example, education providers will need to evaluate their programs and make improvements as appropriate.

Timeframe for development and reporting progress

110. The process for developing the cognitive disability health capability framework will necessarily be somewhat lengthy given that wide consultation is required.

111. As implementation may continue beyond 29 September 2023 when the Royal Commission must report, we direct a recommendation (Recommendation 5) to the Health Council. The Health Council is the Ministerial Council with oversight of the National Scheme under section 11 of the *Health Practitioner Regulation National Law.* It is defined as 'constituted by Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health'.

Recommendations

112. We make the following Recommendations on the development and implementation of a capability or similar framework in cognitive disability health:

Recommendation 1

1. The Australian Medical Council and the Medical Deans Australia and New Zealand should take a joint leadership role to establish a steering committee to develop and co-design:
    a. a cognitive disability health capability framework (capability framework)
    b. associated initiatives that include:
        - a core set of shared, high quality and accessible learning resources and tools for assessing cognitive disability health capabilities
        - an implementation plan for embedding the capabilities from the framework in curricula in education and training programs for health practitioners across all training stages.
2. The steering committee should include people or representatives of bodies that have:
    a. lived experience of cognitive disability
    b. a demonstrated capacity to partner with people with lived experience of cognitive disability
    c. experience in developing and implementing competency or similar frameworks
    d. clinical skills in cognitive disability health
    e. responsibilities for the implementation of the framework in educational programs and health care settings.
3. The steering committee should design and implement an effective process for co-designing the capability framework and associated initiatives with people with cognitive disability, their families and carers, and advocacy groups representing people with cognitive disability.
4. The steering committee should also ensure there is comprehensive consultation on the development and implementation of the capability framework and associated initiatives with:
    a. all peak bodies representing medical, nursing, dental, pharmacy and allied health practitioner education
    b. accreditation authorities
    c. health practitioner regulatory bodies
    d. Australian, state and territory health system education and training bodies.

Recommendation 2

1. The capability framework should be designed to:
    a. apply to all registered and non-registered health professions and address core capabilities and profession-specific capabilities, as necessary
    b. enhance health practitioner curricula across all training stages, including entry-level and post-graduate programs, in service training and CPD.
2. The capability framework should specify the core knowledge, skills and attributes required for the provision of quality health care to people with cognitive disability, including intellectual disability. The framework should incorporate content appropriate to the various stages of education and training. The content should include:
    a. understanding disability and attitudes towards people with disability
    b. the impact of the health care system and health service delivery on people with cognitive disability, including the barriers to quality health care they may face
    c. specific requirements to ensure accessibility and the provision of reasonable adjustments and supports, including communication skills
    d. understanding, preventing and managing 'behaviours of concern', particularly through means other than restrictive practices
    e. appreciating the importance of skills necessary to work collaboratively with families, support people and advocates, and professionals from various health and social disciplines
    f. other general competencies that might apply to a range of vulnerable patient groups, including:
        - working effectively with people with chronic and complex health needs
        - working effectively with people from diverse backgrounds, including First Nations people, people from culturally and linguistically diverse communities and LGBTQI+ communities
        - sourcing information, appropriate services and professional support.

Recommendation 3

The Australian Government should facilitate and support the development and implementation of the capability framework and associated initiatives. To this end:

a. the Australian Government should consider allocating the funding committed to the curriculum development initiative in the *National Roadmap for Improving the Health of People with Intellectual Disability* or provide additional funding to support the development of the capability framework

b. the Australian Government Department of Health should offer and provide secretariat support to the steering committee proposed in Recommendation 1.

Recommendation 4

The steering committee leading the development of the capability framework should report to the Royal Commission within eight months of the publication of this Report on the progress in implementing Recommendations 1 and 2.

Recommendation 5

Beyond the life of the Royal Commission, the Health Council should have responsibility for further development and implementation of the capability framework and associated initiatives to enhance cognitive disability health education and training.

Part 3: Review of accreditation standards

113. A contentious issue raised during Public hearing 10 was whether amending accreditation standards is necessary to ensure education providers develop cognitive disability health content in their programs. Reference to cognitive disability health in accreditation standards would have the effect of mandating curriculum changes by education providers.

114. The *Health Practitioner Regulation National Law* in force in each state and territory (National Law) defines accreditation functions for regulated health professions. The National Law was enacted in all states and territories in 2009 and 2010 to create a uniform national registration and accreditation scheme for registered health practitioners.[68] Queensland was the first jurisdiction to enact the National Law and is the lead jurisdiction. This means that, when any changes to the National Law are agreed to by the Ministerial Council, Queensland submits a bill to its Parliament reflecting the agreed changes and takes all reasonable steps to ensure that the bill is passed.[69] In most jurisdictions, section 4 of the National Law provides that their version of the National Law will be the same as the law in Queensland.[70] Sixteen health professions are regulated under the National Scheme. They include five of the six professions whose representatives gave evidence at Public hearing 10. Speech pathologists are self-regulated and do not fall under the National Scheme.

115. For each regulated health profession, the National Board has assigned an accreditation authority. Accreditation authorities apply accreditation standards for their profession to assess whether education programs should be accredited and to monitor accredited programs and providers to ensure they meet the standards.

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68 *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT); *Health Practitioner Regulation National Law (NSW) 2009* (NSW); *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Practitioner Regulation National Law (Queensland) 2009* (Qld); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas); *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic); *Health Practitioner Regulation National Law (WA) Act 2010* (WA).

69 'Legislation', *National Health Practitioner Ombudsman,* web page, 24 November 2020. <www.nhpo.gov.au/legislation>.

70 This is the case in all jurisdictions except New South Wales, South Australia and Western Australia. In New South Wales, *Health Practitioner Regulation National Law (NSW) 2009* (NSW) s 36 provides that the law and the Queensland law are to be read as one. In South Australia, when the *National Health Practitioner Regulation Law (Queensland) Act 2009* (Qld) is amended, the Governor may, by regulation, modify the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) to give effect to the amendment passed in Queensland: *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) s 4(2). In Western Australia, *the Health Practitioner Regulation National Law (WA) Act 2010* (WA) does not provide a process for the law to be updated when the National Law is amended in Queensland, meaning it can only be amended by an Act of Parliament.

116. Accreditation standards for a health profession are used to assess whether a particular program of study and its education provider give graduates the knowledge, skills and professional attributes necessary to practise the profession in Australia.[71] Education providers must ensure that students receive education and training consistent with standards for entry to practice in the student's health profession.

117. The accreditation standards for the various regulated health professions differ in their format, content and structure, depending on the profession's specific education and training structures and needs.

118. In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.[72] It then submits the proposed standard for approval by the particular discipline's National Board.[73]

119. Each profession also has a set of competency or graduate outcome statements that articulate what is expected of graduates of a program of study for the profession. For some professions, these statements are developed by the accreditation authority for the profession; for others, they are developed by the profession's National Board or by a professional association. However, it is the accreditation standards which bind the education providers.

General versus particular standards

120. A number of accreditation bodies and boards pointed out that, with very limited exceptions, accreditation standards do not specify patient cohorts or population groups. This is because standards are outcomes focused and deliberately do not specify a particular educational approach. It was argued that the standards should promote innovation and flexibility by education providers in designing their own curriculum, and that specifying a population group risks creating a checklist approach and stifling high-quality education.[74] Education providers also emphasised the pressures on curriculum developers constantly to increase the time devoted to specific topics.

71 *National Health Practitioner Regulation Law (Queensland) Act 2009* (Qld) s 5.

72 *National Health Practitioner Regulation Law (Queensland) Act 2009* (Qld) s 46(2).

73 *National Health Practitioner Regulation Law (Queensland) Act 2009* (Qld) ss 46, 47.

74 Exhibit 10-22, 'Statement of Professor Richard Murray', 16 November 2020, 4; Exhibit 10-20, 'Statement of Liza Edwards', 10 November 2020; Transcript, Dr Margaret Gatling, Public Hearing 10, 15 December 2020, P-51; Exhibit 10-19, 'Statement of Professor Chris Brebner', 11 November 2020, p 12.

121. MDANZ accepted nevertheless that there is scope within the standards:

> to better reflect the importance of greater recognition and understanding of the spectrums that exist within our communities and the role of informed and shared decision-making; in particular, recognising and taking into account the particular needs and circumstances of people with a spectrum of abilities, those who are especially disadvantaged.[75]

122. The National Board Chairs' joint response also acknowledged that there may be benefits to being more explicit about the competencies required to meet the needs of people with cognitive disabilities.[76] The AMC agreed that accreditation bodies have a pivotal leadership role, and that accreditation standards are a significant lever for reform. Additional levers include workshops and the sharing of good practice resources.[77] The AMC is prepared to consider Professor Trollor's suggested edits to the accreditation standards for primary medical programs.[78]

123. Speech Pathology Australia supported a review being undertaken of accreditation standards applicable to all registered and self-regulated professions with the aim of improving requirements relevant to people with cognitive disability. It said that amendment of accreditation standards requires an implementation strategy over a transition period.[79] The Australian Pharmacy Council also supported a recommendation that accreditation authorities review their accreditation standards after completing the development of the capability or similar framework.[80]

124. The Australian Dental Council submitted that addressing any stagnation in education will not be resolved by only focusing on amending accreditation standards to be more prescriptive.[81] Other submissions supported accrediting bodies sending 'a clear and emphatic signal' about developing and implementing a curriculum in partnership with people with cognitive disability, family and carers.[82]

125. ANMAC highlighted that any change to the nursing accreditation standards would require approval by the Nursing and Midwifery Board of Australia. However, without such amendment, ANMAC could address cognitive disability health by specifying the capability framework as part of the 'essential evidence' it requires education providers to provide and demonstrate when seeking accreditation.[83]

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75 Exhibit 10-22, 'Statement of Professor Richard Murray', 16 November 2020, p 5.

76 Submission of AHPRA National Board Chairs, Public hearing 10, 14 June 2021, SUBM.0010.0010.0001, p 5.

77 Submission of Australian Medical Council, Public hearing 10, 8 July 2021, SUBM.0010.0019.0001, p 4.

78 Submission of Australian Medical Council, Public hearing 10, 8 July 2021, SUBM.0010.0019.0001, p 3.

79 Submission of Speech Pathology Australia, Public hearing 10, 10 June 2021, SUBM.0010.0014.0001, p 3.

80 Submission of Australian Pharmacy Council, Public hearing 10, 11 June 2021, SUBM.0010.0005.0001, p 3.

81 Submission of Australian Dental Council, Public hearing 10, SUBM.0010.0002.0001, p 3.

82 Submission of University of Sydney, Public hearing 10, 11 June 2021, SUBM.0010.0016.0001.

83 Submission of Australian Nursing and Midwifery Accreditation Council, Public hearing 10, 11 June 2021, SUBM.0010.0004.0001, pp 2-3.

126. The Australian Government proposed that accreditation authorities should revise their accreditation standards to require educational curricula equip health professionals with the competencies identified in the competency framework.[84] The Australian Government also proposed that it should seek agreement from all states and territories to direct professional bodies to ensure that accreditation standards include the competency framework.

Amending accreditation standards

127. Accreditation standards and processes are a critically important quality assurance process for ensuring programs meet appropriate standards and protect the public. The accreditation of health discipline programs should ensure that practitioners who complete those programs have the knowledge, skills and professional attributes to practise their professions. As noted earlier, the amendment of accreditation standards resulted in critical changes to incorporate indigenous health content in health science degrees across the country.

128. We accept Counsel Assisting's submission that the accreditation bodies have a critical role in enhancing health professionals' understanding of and responses to the specific health needs of people with cognitive disability. Accordingly, we find that educational curricula are unlikely to incorporate enhanced training on cognitive disability health without amendments to the accreditation standards (Finding 5).

Finding 5

Unless accreditation standards are revised, there is unlikely to be substantive change to educational curricula to incorporate enhanced training on cognitive disability health. Generalised accreditation standards are unlikely to be sufficient to ensure changes are made to curricula to embed cognitive disability health capabilities.

129. The Royal Commission received evidence that the status of curriculum content addressing the specific needs of people with cognitive disability has been fragile, relying to a significant extent on the efforts of individual academics or 'champions' for its inclusion in health practitioner programs. We make that finding (Finding 6). The work of Dr Jane Tracy, Ms Virginia Howie and Associate Professor John Wilson in teaching cognitive disability content provides examples, including their experience of course subjects being easily abandoned by education providers and internal curriculum developers. They spoke at Public hearing 10 in favour of an increased and more sustainable focus on the health care of people with cognitive disability in education programs across the health professions.

84 Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, p 14.

Finding 6

The inclusion and comprehensiveness of cognitive disability health content in health practitioner programs have depended significantly on individual academics to support or 'champion' its inclusion. Curriculum content in this area is variable, inconsistent and prone to being discontinued if the champions leave or are no longer available to provide leadership. There is scope to incorporate and integrate cognitive disability health content in health practitioner programs, and to do so in a sustainable manner.

130. From her wealth of experience in this work,[85] Dr Tracy explained that disability-related content can be readily woven into medical and other curricula when students are learning about child and adolescent development, general practice, psychiatry, women's health, palliative care, communication skills, rehabilitation, aged care, and legal and ethical issues. In her view, it is important that the teaching focuses on adults with disability. While the case examples used by universities are typically paediatric examples, 'people live most of their life as adults and it is adult medicine that we really need to influence'.[86]

131. Dr Tracy also addressed the argument regarding a 'crowded curriculum'. She and Professor Rachael McDonald have suggested that, for this content to be included, curriculum decision-makers should view teaching sessions and resources in one or more of the following ways:[87]

- as addressing current national health priorities (mental health, dementia and obesity) and related policy areas (such as chronic disease management)
- as being responsive to social, legislative and policy change (such as the NDIS)
- as applying to curriculum areas earmarked for emphasis (interprofessional education, ethical and professional behaviour)
- as providing opportunities for integration of curriculum across medical discipline boundaries
- as having wider relevance to population health issues (such as disadvantaged populations and the cost of health care).

85 The Centre for Development Disability Health in Victoria has been developing and delivering training modules and educational resources for undergraduate medical, dental and allied health degrees in cognitive disability health since about 1997.

86 Transcript, Dr Jane Tracy, Public Hearing 10, 15 December 2020, P-18.

87 Exhibit 10-74, J Tracy and R McDonald, 'Health and Disability: Partnerships in Health care' (2015) 28 *Journal of Applied Research in Intellectual Disabilities*, p 22.

132. Dr Tracy and Professor McDonald argued that a focus on the health care of people with intellectual and associated developmental disabilities provides an effective platform for teaching the necessary competencies applicable not only to people with cognitive disability, but also to other vulnerable patient groups. Competencies generally applicable include:

- knowledge and skills required to work effectively with people with chronic and complex needs
- ability to recognise and address cognitive and communication difficulties
- willingness to work with carers and advocates
- ability to work collaboratively in health care teams
- understanding how to source information, appropriate services and professional support.

133. Dr Tracy and Professor McDonald also identified the need to impart specific competencies relating to health risks and vulnerabilities associated with particular disabilities, such as Down syndrome or cerebral palsy. They suggested that an understanding of common disabilities and their implications for health and health care are required, as is knowledge of how to source information about less common conditions.

Recommendations

134. The Report on Public hearing 4 catalogues the formidable barriers to quality health care in Australia for people with cognitive disability. It also highlights instances where this has led to poor quality or inappropriate health care, with at times serious or tragic consequences. The evidence at Public hearing 10 reinforced the views expressed in the Report on Public hearing 4.

135. We acknowledge that accreditation standards are broadly framed and do not generally address the needs of particular population groups. However, the Report on Public hearing 4 found continued systemic neglect of the health needs of people with cognitive disability in the Australian health system. We heard compelling evidence that an important strategy for addressing that neglect is elevating the education and training of health professionals in cognitive disability health.

136. A recommendation that accreditation standards should require education in the health of people with cognitive disability does not imply that teaching be conducted in a specific manner or separately from other topics. As the many academics who gave evidence in Public hearing 10 explained, it is more effective to integrate core concepts within the curriculum to enable students to develop competence over time. This helps

students to apply their competences in clinical practice and in the wide range of health settings in which they will encounter people with cognitive disability.[88] Dr Tracy's evidence supports the view that this approach is achievable.

137. We accept Counsel Assisting's Submissions that Professor Trollor demonstrated at Public hearing 10 that there is scope within the accreditation standards for medical specialist degrees to better reflect an understanding of intellectual disability health in the standards.[89] We infer that there is similar scope in accreditation standards in the other health disciplines.

138. We have considered whether it is open to the Australian Government to seek agreement from states and territories to direct the professional bodies to ensure accreditation standards include the competency framework as an addendum (as submitted by the Australian Government). We do not think this is an available pathway to amend accreditation standards.[90]

139. Accordingly, we make the following recommendations:

Recommendation 6

The accreditation authorities for registered health professions and the peak professional bodies for non-registered health professions should review the accreditation standards and evidence requirements for education providers and consider whether cognitive disability health is sufficiently covered. If it is not, they should amend their accreditation standards or evidence requirements (as the case may be) accordingly.

88 For example, Transcript, Professor Rosalind Bull, Public Hearing 10, 15 December 2020, P-27-28; Transcript, Professor Michelle Leech, Public Hearing 10, 15 December 2020, P-19, PP-21-22.

89 Transcript, Professor Julian Trollor, Public Hearing 10, 16 December 2020, P-170-172.

90 Noting *National Health Practitioner Regulation Law (Queensland) Act 2009* (Qld) s 11(4), which provides that the Ministerial Council may give a National Board a direction relating to particular proposed accreditation standard, or a particular proposed amendment of an accreditation standard, for a health profession only if (a) in the Council's opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners; and (b) the Council has first given consideration to the potential impact of the Council's direction on the quality and safety of health care.

Recommendation 7

The accreditation authorities for registered health professions and the peak professional bodies for non-registered health professions should encourage or mandate education providers to:

a. develop curriculum content relating specifically to cognitive disability health and do so in conjunction with people with cognitive disability

b. deliver such content using inclusive teaching practices and do so involving people with cognitive disability where possible.

Recommendation 8

The accreditation authorities for registered health professions and the peak professional bodies for non-registered health professions should report to the Royal Commission within eight months of the publication of this Report on progress in implementing Recommendations 6 and 7.

140. We acknowledge that accreditation standards are reviewed at about five-year intervals. Accreditation authorities that have only recently completed a review should consider mechanisms to address Recommendations 6 to 8 pending the next scheduled review.

Part 4: Clinical placements

141. The Royal Commission has been told about the importance of student clinical placements for preparing graduates to care for patients or clients with cognitive disability.[91] Clinical placements provide an important opportunity for students to practise under supervision and to develop communication and clinical skills specifically relating to cognitive disabilities in an interprofessional environment.

142. Counsel Assisting's Submissions outlined the requirements for clinical placements in each of the six professions examined in Public hearing 10. Under accreditation standards, each profession requires practical experience in a variety of settings relevant to the curriculum.

143. There are generally no dedicated placements for cognitive disability health. In some disciplines, such as speech pathology, cognitive disability has more focus than others. Because of the nature of the work, the majority of speech pathology students have the opportunity to work with people with disability during placements in private practices, health services or larger disability organisations. In dentistry and oral health, students undertake special needs dentistry placements in public hospitals. Witnesses from each of the professions identified significant gaps in opportunities for supervised placements due to funding arrangements, including under the NDIS.

144. Education providers expressed enthusiasm for expanding work-based experiences in cognitive disability health in both clinical and non-clinical contexts. Education providers (including RANZCP, RACP and several universities) and professional bodies and associations (AMC, APS and AHPA) said that clinical placements allowing students to care for people with cognitive disability are limited in number. They agreed that additional placement opportunities of high quality are needed. These should be in diverse settings where students can gain experience in caring for people with cognitive disability and are supervised while working as part of a multidisciplinary team.

145. Experts in cognitive disability health welcomed the focus in Public hearing 10 on clinical placements and interprofessional education, but suggested that non-clinical placements should also be considered and used. Professor Trollor observed that non-clinical settings can offer 'valuable experiences which engender greater understanding of the context of support for people with disability'.[92] One expert cautioned, however, that a reliance on segregated settings can reinforce concepts of difference.[93]

146. Education providers, professional associations and accreditation authorities identified funding mechanisms as a major barrier to the expansion of clinical placements. For example, in medicine, state and territory public hospitals are funded to provide

91 A clinical placement is a structured period of supervised clinical experience and learning in a health or community setting. It is planned and structured to enable students to demonstrate graduate outcomes.

92 Submission of Professor Julian Trollor, Public hearing 10, SUBM.0010.0008.0118, p 68.

93 Submission of Dr Jane Tracy, Public hearing 10, SUBM.0010.0007.0001, p 1.

clinical teaching and supervision under the Addendum to the National Health Reform Agreement. The Australian Government also provides direct financial support for clinical learning in community general practice settings through the Practice Incentives Program payments. However, financial support for supervision and learning in other community settings is lacking, notably aged care, disability services and community health. This significantly limits the scope for medical students to participate in quality supervised placement opportunities in those settings.

147. We heard that in the psychology profession, it is difficult to find practitioners with the time to supervise trainees. Clinical psychologists in private practice are apparently less willing to supervise than once was the case, in part because NDIS funding arrangements provide no incentive to undertake that responsibility.[94] The same observation was made by Speech Pathology Australia.[95] Allied Health Professions Australia also emphasised that training opportunities in the disability sector have significantly reduced since disability services were largely devolved to the NDIS.[96]

148. We accept Counsel Assisting's submission that the evidence supports findings that:

- Clinical placements do not consistently prepare students with skills to provide care for patients with cognitive disabilities. Not all students have access to clinical experiences in cognitive disability health.
- While education providers expect students to be exposed to patients with cognitive disabilities in clinical placements, they do not systematically ensure that students have the opportunity to develop skills in cognitive disability health care, nor that clinical placement providers are equipped to provide those opportunities.
- Greater use should be made of non-clinical settings to provide more opportunities for supervised learning with patients with cognitive disability, particularly in medicine.
- Funding structures should foster a broader range of opportunities for supervised clinical placements.

94 Transcript, Dr Zena Burgess, Public Hearing 10, 2 March 2021, P-246; Transcript, Rachel Phillips, Public Hearing 10, 2 March 2021, P-247–248.

95 Transcript, Stacey Baldac, Public Hearing 10, 2 March 2021, P-215.

96 Transcript, Claire Hewat, Public Hearing 10, 2 March 2021, PP-201–202.

149. We make findings to this effect (Finding 7).

Finding 7

Clinical placements are a vital feature of training to prepare health practitioners for practice. They provide an important opportunity to expose students to patients or clients with cognitive disability under supervision. However, currently:

a. Clinical placements do not consistently prepare students with skills to provide care for patients with cognitive disabilities.

b. Not all students have access to clinical experiences relevant to cognitive disability health.

c. While education providers expect students to be exposed to patients with cognitive disabilities in clinical placements, they do not systematically ensure opportunities are provided to develop skills in cognitive disability, nor that clinical placement providers are equipped to provide those opportunities.

d. Settings outside the traditional clinical environments of public hospitals need to be expanded to provide more opportunities for supervised learning with patients with cognitive disabilities, particularly in medicine.

e. Funding structures are critical to the ability of education providers to provide a broader range of opportunities for supervised clinical placements in cognitive disability health.

150. The Australian Government pointed out that options to expand student placements in disability settings are included in the National Roadmap as a medium-term action,[97] and that the NDIS National Workforce Plan includes an initiative to increase the number of traineeships and student placements. The Australian Government also pointed out that government funding to universities supports student placements, but acknowledged there is 'an opportunity for the Government to invest in innovative solutions to promote growth in student placements in areas of particular need, such as regional and remote communities, including through the Boosting the Local Care Workforce'.

97 Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, p 19.

Recommendations

151. Participants in Public hearing 10 strongly supported the proposed recommendations regarding clinical placements.[98] We make those recommendations.

152. It is clear education providers seek to expand opportunities for students to undertake clinical placements that would provide them with more comprehensive cognitive disability health training. It is also clear that funding mechanisms are perceived both as a barrier and as the most significant potential lever to enhance such opportunities. While acute public hospitals have been the traditional centre of clinical learning (and this is where funding is predominantly directed), future practice will be increasingly in community and home-based settings. Some witnesses referred to the lack of funding mechanisms as a 'major gap' in providing training opportunities. A key requirement is funding of supervisors for time spent in the allied health professions overseeing and training students, including funding through the NDIS.

153. We accept Counsel Assisting's submission that, in implementing the Australian Government's National Roadmap, the Australian Government Department of Health is well placed to explore with education providers, State and Territory governments and other stakeholders the potential avenues for enhanced clinical placement opportunities in cognitive disability health, including through funding mechanisms.

154. While funding is one barrier to ensuring adequate clinical placements, limited capacity to supervise placements is also a barrier. This is not an issue that can be resolved quickly. However, implementing the cognitive disability health capability framework across health professional education and training will improve the effective supervision of students on clinical placements.

155. We are also satisfied that education providers can take more active steps to explore with all clinical placement providers opportunities for student learning and development in cognitive disability health. Accreditation authorities are well placed to encourage this. As one submission said, this could also include education providers developing interprofessional clinical placement opportunities by supporting cross-discipline placements in services at the same time.[99]

98 Including Submission of Medical Deans of Australia and New Zealand, Public hearing 10, 7 June 2021, SUBM.0010.0009.0001; Submission of Australian Dental Council, Public hearing 10, SUBM.0010.0002.0001, p 3; Submission of University of Sydney, Public hearing 10, 11 June 2021, SUBM.0010.0016.0001; Submission of Australian Psychological Society, Public hearing 10, 11 June 2021, SUBM.0010.0006.0001, p 3; Submission of Allied Health Professions Australia, Public hearing 10, June 2021.

99 Submission of Speech Pathology Australia, Public hearing 10, 10 June 2021, SUBM.0010.0014.0001, p 2.

156. Accordingly, we make the following recommendations:

Recommendation 9

Education providers should explore with clinical placement providers, across the range of settings in which clinical placements take place, increased opportunities for student learning and development in cognitive disability health, including as part of interprofessional teams.

Recommendation 10

As part of the implementation of the *National Roadmap for Improving the Health of People with Intellectual Disability* (July 2021), the Australian Government should consider mechanisms to enhance funded supervised clinical and work-based training placements to train students in providing quality health care to people with cognitive disability. This should include enhanced financial support for clinical placement and supervision in community settings.

157. At the same time as we ask for reports from the steering committee and accreditation authorities (see Recommendations 4 and 8), we shall ask the Australian Government for information concerning its support for the development and implementation of the capability framework (Recommendations 3) and enhanced financial support for supervised clinical placement and work-based training placements (Recommendation 10).

Part 5: Post-graduate training and continuing professional development

158. The Royal Commission has examined the education and training provided by the medical colleges that provide specialist qualifications to psychiatrists, physicians, anaesthetists, general practitioners, rural and remote medicine specialists and emergency physicians.

159. We explored two main issues. The first issue is whether a capability framework should be designed to apply to postgraduate medical training and CPD (not only to primary degrees). As outlined in Part 2 of this Report, we are satisfied that it should do so.

160. The second issue is whether sufficient subspecialty training pathways are available for doctors interested in specialising in cognitive disability health. The Royal Commission received evidence, particularly in Public hearings 4 and 6, that the supply of intellectual disability specialists is limited, in particular for adult patients. Improved career pathways for aspiring disability specialists are needed, notably in general practice, paediatrics, psychiatry, rehabilitation medicine and emergency medicine.

161. Public hearing 10 also examined whether there are adequate CPD opportunities for health professionals practising in the six professions examined (medicine, nursing, dentistry and oral health, speech pathology, pharmacy and psychology). Counsel Assisting's Submissions outlined the requirements under the National Law for continuing professional education in each of the professions and the evidence about the availability and importance of CPD learning opportunities in cognitive disability health.

162. The Joint National Boards, education providers and the Australian Government supported or supported in principle a proposed recommendation that education providers and professional bodies in medicine and dentistry review their CPD programs, and enhance and promote CPD for the provision of health care to people with cognitive disability. The Australian Government submitted that any recommendation should also apply to the allied health and nursing professions.[100] We accept that submission and have expanded Counsel Assisting's proposed recommendation.

163. The evidence clearly pointed to a lack of CPD opportunities for health professionals across the six health disciplines, particularly in the area of intellectual disability health. Accordingly, we make a finding to this effect (Finding 8). Our recommendation is intended to strengthen CPD opportunities for health practitioners for the care of patients with intellectual or cognitive disabilities. We anticipate that the proposed capability framework will usefully inform CPD activities that health professionals can undertake. However, implementing our recommendation should not wait for the full implementation of the capability framework.

100 Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, p 17.

Finding 8

Health professionals often lack access to relevant CPD training, particularly in the area of intellectual disability health, across the medicine, nursing, dentistry, pharmacy, psychology and speech pathology professions.

Career pathways in cognitive disability health

164. Counsel Assisting's Submissions summarises the evidence obtained by the Royal Commission on the training pathways available in each medical specialty for a doctor who is interested in becoming a specialist in intellectual or cognitive disability, or who is interested in developing advanced skills in that area and having them recognised. Currently there is no clear pathway available in any of the specialties examined. An individual can create opportunities for subspecialisation, but this is a challenging process.

165. We heard evidence about repeated calls for subspecialty training in intellectual disability and mental health for psychiatrists. We also heard that RANZCP is developing a program leading to a certificate of advanced training.[101]

166. Counsel Assisting did not propose any specific recommendations but submitted that we should consider:

- inviting the Colleges to review their curricula for general practitioners, paediatricians, physicians (including rehabilitation physicians), emergency medicine specialists, anaesthetists and psychiatrists to determine what further training should be offered, once a capability framework is developed
- inviting the ANZCA and ACEM to review their respective curricula and assessment methods, to determine whether the content relating to the care of people with cognitive disability should be enhanced
- following up six months after completion of this Report to determine what progress has been made in response to the invitations.

167. The Australian Government submitted that a six-month timeframe is too short, given that the capability or similar framework may not be completed in that timeframe.[102]

101 Exhibit 10-67, Claire Eagleson, Rachael Cvejic, Janelle Weise and Julian Trollor, 'Subspecialty training pathways in intellectual and developmental disability psychiatry in Australia and New Zealand: current status and future opportunities', (2019), 27(5) *Australasian Psychiatry.*

102 Submission of Australian Government, Public hearing 10, 23 June 2021, SUBM.0010.0018.0001, p 17.

Recommendations

168. We propose to go further than Counsel Assisting's submission by recommending that RACP, RANZCP, ANZCA, RACGP, ACEM and ACRRM should develop training content in cognitive disability health for basic training courses.

169. While each of the Colleges has basic and advanced training, the evidence indicates that core aptitudes in cognitive disability health are not systematically covered. We expect that the Colleges will participate in the development of the cognitive disability health capability (or similar) framework and will consider the degree to which the content is already covered in their training programs. The development of the cognitive disability health capability framework will allow the Colleges to review their programs and to consult as proposed in this Report.

170. We are also keen to support pathways for sub-speciality training in cognitive disability health. But we acknowledge that the ability to promote pathways for sub-speciality training depends on the availability of funded training positions. A medium-term action in the National Roadmap (with a four- to six-year timeframe) is to embed training within specialist training programs, including working with the Colleges to develop curriculum for a subspecialty or similar career pathway in intellectual disability. Our recommendation aligns with the consensus reached during the National Roadmap process which is consistent with the evidence we have received, particularly during Public hearing 10.

171. Accordingly, we make the following recommendations:

Recommendation 11

The Colleges RACP, RANZCP, ANZCA, RACGP, ACEM and ACRRM should each:

a. develop specialised training content in cognitive disability health for different areas of specialisation, building on the capability framework and the core set of learning resources, so that future specialists can develop skills and competencies in cognitive disability health

b. expand and promote pathways for sub-speciality training in cognitive disability health.

Recommendation 12

The Colleges RACP, RANZCP, ANZCA, RACGP, ACEM and ACRRM, the Australian Dental Association and professional bodies responsible for CPD in the nursing and allied health professions should each:

a. review CPD programs in their respective health discipline or specialty to determine whether CPD for the provision of health care to people with cognitive disability, including intellectual and/or developmental disabilities, should be enhanced

b. promote the development of CPD opportunities on the provision of health care to people with cognitive disability, including intellectual and/or developmental disabilities

c. raise awareness of such CPD opportunities among members

d. report to the Royal Commission within eight months of the publication of this Report on progress in implementing this Recommendation.

Part 6: A national Centre of Excellence

172. Proposition 11 examined at Public hearing 10 proposed:

> Consideration should be given to:
>
> a) establishing a network of Centres of Excellence on Cognitive Disability, as hubs for training, education and resource
> b) developing additional or shared teaching resources to assist education providers in providing additional, appropriate training and education to health professionals
> c) strengthening and establishing opportunities for health professionals to access training and resources, including utilising primary health networks
> d) establishing a national online repository, available to all health professionals, to hold information, training resources and evidence-based tools regarding providing health care to people with cognitive disability.

173. Counsel Assisting formulated Proposition 11 based on the information and submissions received by the Royal Commission in the lead up to the Public hearing and in Public hearing 4.

174. Witnesses at Public hearing 4 and Public hearing 10 gave evidence in support of the establishment of a network of centres or national centre of excellence on intellectual or cognitive disability health. While centres of excellence already exist in Australia, there is no national network or strategy to support their work. For example, Dr Jane Tracy said that existing specialist services, such as the Centre for Developmental Disability Health in Victoria, could achieve more with the support of a national network of specialised services. Mr Jim Simpson noted that the creation of a network of specialised intellectual disability health services would support the mainstream health system to respond appropriately to people with intellectual disability.[103]

175. Professor Julian Trollor said that a national training centre and resource clearing house would equip the workforce by developing, collating and disseminating resources for health professionals to support improved practice for people with intellectual disability and those on the autism spectrum.[104] He noted this had been a recommendation of the National Roundtable on the mental health of people with intellectual disability held in 2018, with sector support at the highest level.

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103 Exhibit 4-20, 'Statement of James Simpson', 12 February 2020 [15]; Transcript, James Simpson, Public Hearing 4, 25 February 2020, P-517–519.

104 Exhibit 4-9, 'Statement of Professor Julian Trollor', 11 February 2020, [254]; Transcript, Professor Julian Trollor, Public Hearing 4, 20 February 2020, P-205.

176. At Public hearing 4, the Royal Commission received detailed evidence about the establishment in New South Wales of specialised teams for intellectual disability health and intellectual disability/mental health specialist hubs. It was said that a national network of specialised intellectual disability health services should be developed to share knowledge and support the delivery of clinical services. It appears that work done in one State is not necessarily disseminated to groups in other States to enable them to take advantage of that work.

177. We also heard about the work being done by the Council for Intellectual Disability and primary health networks – particularly Central and Eastern Sydney Primary Health Network – in the Primary Care Enhancement Program to develop a national set of resources to support general practices to deliver health care to patients with intellectual disability. As noted in Part 2 above, education providers emphasised that a set of universally accessible, shared resources for teaching cognitive disability health would be very valuable.[105] This would enable the outstanding work done by individual researchers and clinicians to benefit health professionals across the country as they learn about the health care of people with cognitive disability.

178. Professor Abernethy, Executive Dean of the Faculty of Health and Behavioural Sciences at the University of Queensland, said that a centre of excellence would generally have a strong research component. In his view, the best models for health science centres of excellence include a number of components: delivery of health care; education of future and present practitioners; and research into and development of best practice. He said a centre or centres that address all three elements would have significant support from the university sector. He agreed that a fourth element would involve coordination of a range of institutions.[106]

179. The other evidence and submissions received by the Royal Commission on the need for a national centre of excellence and related reforms (including the centralisation of resources to support improved education, training and practice in cognitive disability health) are summarised in Counsel Assisting's Submissions and the Hearing Report for Public hearing 4.

180. Our recommendation in this Report about the development of a cognitive disability health capability framework with a set of shared, high quality and accessible learning resources (Recommendation 1) will, if implemented, contribute to the goal of

105 Transcript, Professor Rosalind Bull, Public Hearing 10, 15 December 2020, P-17; Professor Richard Murray, Transcript of meeting with AMC and MDANZ, p 9; Exhibit 4-9, 'Statement of Professor Julian Trollor', 11 February 2020, [254]; Transcript, Professor Michelle Leech, Public Hearing 10, 15 December 2020, P-26; Transcript, Professor Gary Velan, Public Hearing 10, 15 December 2020, P-32-3; Transcript, Bronwyn Clark, Public Hearing 10, 2 March 2021, P-234; Transcript, Professor Richard Murray, Public Hearing 10, 15 December 2020, P-84, P-87; Exhibit 10-8, 'Statement of Associate Professor Mark Lane', 14 February 2020, 15; Transcript, Professor Inam Haq, Public Hearing 10, 15 December 2020, P-87 [10-17].

106 Transcript, Professor Bruce Abernethy, Public Hearing 10, 2 March 2021, P-234.

establishing nationally shared resources in cognitive disability health that reflect best practice.

181. Experts broadly agree about the need to centralise and share resources that can be used to support improved training and practice in cognitive disability health. We are satisfied that there would be great value in establishing a network of centres or national centre of excellence to bring together expertise and lead research in cognitive disability health to support the translation of research findings into practice nationally. We make a finding to this effect (Finding 9).

Finding 9

Experts and education providers agree that it would be valuable to centralise and share resources to support improved education, training and practice in cognitive disability health. There is also broad support for the establishment of a network of centres of excellence or a national centre of excellence to bring together expertise and lead research in cognitive disability health to support the translation of research findings into practice nationally.

182. The establishment of a national centre of excellence was a key discussion point raised in developing the National Roadmap. A short term (one to three year) action in the National Roadmap is for the Australian Government Department of Health to:

- consult on establishing a National Centre of Excellence in Intellectual Disability Health that leads research in intellectual disability health, synthesises and disseminates research, and supports the translation of research findings into practice
- work towards establishing a central repository for intellectual disability health content and resources for people with intellectual disability, their families and support providers, health students, professionals and their educators, including shared language and concepts around human rights, communication, consent and decision making.

183. As stated in the National Roadmap, the Australian Government's 2021-22 Budget provided $12.7 million to implement priority actions under the Roadmap. The priority actions include scoping a model for a new National Centre of Excellence in Intellectual Disability Health. The Centre is to provide national leadership on the health care of people with intellectual disability and is to be a central hub of expertise and resources for health and disability service providers across the country. A medium-term action under the National Roadmap is for the Australian Government Department of Health to work with states and territories to build on the proposed establishment of a National Centre of Excellence by further developing a national network of specialised intellectual disability health services.

184. In a response dated 14 September 2021 to a notice from the Royal Commission to provide information, the Australian Government Department of Health said that the Australian Government has allocated funding of $1.4 million as part of the 2021-22 Budget for scoping and co-design of an effective and cost-efficient national centre of excellence in intellectual disability health.[107] The Department has engaged a consultant to lead the work. The consultant will provide written advice and recommendations to the Department on the most effective and efficient options for the model for the Centre for Excellence, and detailed cost estimates for each option. The scoping and co-design work is due to be completed by 31 January 2022 and will inform further advice to Government.

185. The Australian Government Department of Health further states that it is envisaged that the role of a Centre for Excellence would include leading advancement of research and evidence in intellectual disability health, including by:

- supporting research translation activities in intellectual disability health
- monitoring and review of intellectual disability health practice and research evidence
- supporting the development of data on the health of people with intellectual disability, to help enable monitoring and evaluation of policy initiatives and interventions and support
- promoting continuous improvement.

186. We strongly support the establishment of a national centre of excellence and are encouraged by the initiatives already underway. We accept Counsel Assisting's submission that there are multiple ways in which a centre of excellence or similar network could be developed. No submission has been made to the Royal Commission by any person or body proposing a particular model for funding or development that the Royal Commission could assess. Therefore, we are not in a position to make precise recommendations on this issue. However, it is clear that the practical development of any further centre of excellence requires the support of education providers, Government and specialised health services, among others, and that such support is very likely to be forthcoming with Australian Government support.

187. We will revisit the outcomes of the scoping and co-design process and progress made on the creation of such a centre in our Final Report.

107 Australian Government Department of Health, Response to Notice to Give a Statement in Writing NTG-00162, 14 September 2021, CTD.8000.0018.1919.

Appendices

Appendix A: Parties with Leave to appear and legal representatives

Party with Leave to appear	Legal representatives
Commonwealth of Australia	A Munro and M Costello instructed by Gilbert + Tobin
State of New South Wales	G Furness SC instructed by New South Wales Crown Solicitor
State of Victoria	R Bedford and S Chesterman Minter Ellison
State of Queensland	K McMillan QC and P Clohessy instructed by Queensland Crown Law
Monash University	M Marcus instructed by General Counsel for Monash University
University of Tasmania	A Herbon
University of New South Wales	E Grinston
Royal Australian College of General Practitioners	R Feltoe
Pharmacy Board of Australia and the Psychology Board of Australia	G Gregg instructed by Sparke Helmore Lawyers

Appendix B: Propositions developed prior to Public hearing 10

Introduction

The Royal Commission will hold a public hearing in Sydney on Tuesday 15 December 2020 and Wednesday 16 December 2020. The hearing will examine the education and training of health professionals in the health care and treatment of people with cognitive disability.

Background

The Royal Commission's terms of reference require the Royal Commission to inquire into:

> (a) what governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, having regard to the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts;
>
> …
>
> (c) what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation;
>
> ….
>
> (f) all aspects of quality and safety of services, including informal support, provided by governments, institutions and the community to people with disability, including the National Disability Insurance Scheme (NDIS) and the NDIS Quality and Safeguarding Framework agreed by all Australian Governments in 2017.

During Public hearing 4: Health care and services for people with cognitive disability, Public hearing 5: Impact of COVID-19 on people with disability, Public hearing 6: Psychotropic medication, behaviour support and behaviours of concern, the Royal Commission heard about the significant health inequities experienced by people with cognitive disability, including the multiple barriers to effective health care, and high rates of premature and potentially avoidable deaths, they face.

Cognitive disability arises from the interaction between a person with cognitive impairment and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. 'Cognitive impairment' is an umbrella term to encompass actual or perceived differences in cognition, including concentration, processing, remembering, or communicating information, learning, awareness, and/or decision-making.

The evidence also began to explore the need for better training for medical and other health professionals to address the unmet health needs of people with cognitive disability.

The Hearing report for Public hearing 4 identified issues the Commissioners consider should be the subject of further inquiry:

> The Royal Commission will consider how training and education of health professionals can result in better quality health care and outcomes for people with cognitive disability. In particular, the Royal Commission will investigate further:
>
> - the nature and content of training relating to cognitive disability currently provided to people studying to become health professionals or already practising as health professionals;
> - the extent to which training programs currently involve the participation of people with cognitive disability, their families, carers or support persons;
> - the effectiveness of education programs designed to improve communication between health professionals and people with cognitive disability and to address unconscious bias and negative assumptions held by health professionals about the value of lives led by people with cognitive disability; and
> - the nature of training and education required to equip health professionals with the skills, knowledge and understanding necessary for the correct diagnosis of conditions experienced by people with cognitive disability and to avoid diagnostic overshadowing.

Scope of this hearing

The hearing will examine the education and training of health professionals, such as doctors, nurses, dentists, pharmacists and psychologists, in the health care and treatment of people with cognitive disability.

The issues to be explored at the hearing will include:

a. content of curricula at undergraduate and post-graduate medical, dental and nursing schools and colleges relating to the health needs of people with cognitive disability and areas of curricula redevelopment to better support people with cognitive disability

b. accreditation and oversight of education and training programs

c. practice standards and professional competencies

d. post-registration and specialty education and training as well as continuing professional development

e. the extent of involvement of people with cognitive disability and, where appropriate, their families and support persons in the education and training of health professionals

f. the need for and effectiveness of education and training to address:

   i) diagnostic overshadowing and the misdiagnosis of health conditions in people with cognitive disability
   ii) cultural attitudes, assumptions and beliefs about the quality of life and value of people with cognitive disability
   iii) communication with people with cognitive disability and their families and support persons, and
   iv) gaps in specialised knowledge in cognitive disability.

Outline

This document sets out a series of propositions relating to the topics of training and education of health professionals in relation to people with cognitive disability. The propositions have been developed by Counsel Assisting and staff of the Office of the Royal Commission to examine at Public hearing 10. The propositions do not necessarily represent the views of the Royal Commissioners or the submissions that Counsel Assisting will make at the hearing. They are put forward for inquiry and testing.

Propositions

Issues and challenges

The evidence from Public Hearing 4 and Public Hearing 6 will be relied on for this hearing. The evidence revealed that:

1. Additional and improved training of health professionals is needed to ensure they are equipped to provide quality health care to people with cognitive disability on an equal basis with others.
2. The education and training across universities of health professionals, in relation to the health needs of people with cognitive disability, varies considerably.
3. Inadequate guidance currently exists for those developing and reviewing curricula or developing continuing professional development training, on the level and extent of content that should address health care of people with cognitive disability.
4. Education and training on the health care needs of people with cognitive disability should be embedded throughout curricula, at various levels of education and training for health professionals and during practice.

Propositions – areas of change

The propositions for change are grouped into three main categories:

a. Framework, which proposes the development of a standardised competency framework to guide the development of all reforms to education and training.

b. Fundamentals, which proposes key content and procedural elements that should guide and inform all training and education.

c. Training phases, which sets out propositions specific to stages of education and training.

Competency Framework

Proposition 1: competency framework

1.1 A competency framework for health professionals should be developed promptly, including for medical practitioners, nurses, dentists, clinical pharmacists, psychologists, and relevant allied health professionals.

1.2 To develop a competency framework, there should be consultation between people with disability, their family and support persons (where appropriate) and stakeholders in the higher education system, health professionals, and accreditation bodies.

1.3 The competency framework should specify the core knowledge, skills and attributes required by health professionals to equip them to provide quality health care to people with cognitive disability.

1.4 It should also provide guidance on:

a. the fundamentals within all training and education related to the health care of people with cognitive disability, including the appropriate modes of teaching, and assessment and learning outcomes

b. education and training required at different education levels, different clinical focuses, and by public and private health providers

c. further education and training required, tiered in specificity and complexity, based on a health professional's role

d. where to find teaching resources and to assist education providers in implementing revised education and training

Propositions 2 to 11 provide further detail on (a)-(d).

Fundamentals of training

The competency framework should outline and further develop the following procedural and content fundamentals for all training and education related to the health care of people with cognitive disability.

Proposition 2: active involvement of people with cognitive disability

Bodies responsible for training and educating accredited health professionals should seek to ensure that all curriculum or course content specifically relating to people with cognitive disability:

a. is developed and evaluated in conjunction with people with cognitive disability
b. is delivered using inclusive teaching practices and involving people with cognitive disability
c. involves, where appropriate and ethical, direct clinical contact with people with cognitive disability.

Proposition 3: Understanding of disability and attitudes

At appropriate points, training and education for health professionals should cover:

a. Disability theories and models, including the cultural and social context of disability, and respectful terminology
b. How bias and prejudice may affect decision-making around health care for people with cognitive disability, including leading to diagnostic overshadowing
c. The role of leadership and organisational and workplace culture in addressing unconscious bias and requiring respectful values and behaviours.

Proposition 4: accessibility, adjustments and supports

At appropriate points, training and education for health professionals should address:

a. the importance of ensuring physical environments, facilities, information and communication is accessible, and providing practical advice on how health professional make their practice accessible
b. the role and legal requirements around adjustments, including examples of adjustments that may be required to provide quality health care to people with

cognitive disability on an equal basis with others, and practical guidance on implementation

c. communication knowledge and skills, including on adapted, alternative and augmentative communication and working with interpreters

d. the supports a person with cognitive disability may use in decision-making and providing consent, and how health professionals can respect and facilitate these supports.

Proposition 5: collaboration and a multi-disciplinary approach

At appropriate points, training and education for health professionals should address the importance and skills necessary to work collaboratively with:

a. families, support people and advocates

b. professionals from various health and social disciplines.

Training phases

University and vocational education – curricula review and reform

Proposition 6: core education and training in university and vocational study

6.1 Curriculum developers should review and revise curricula for primary medical programs, nursing, and dentistry to incorporate or enhance existing content on health care of people with cognitive disability. This should be repeated as and when the competency framework becomes available.

6.2 Consideration should be given to whether to introduce discrete education modules specifically on health care for cognitive disability as well as inclusion where relevant in other modules.

Proposition 7: supervised clinical placements

Mechanisms to enhance funded supervised clinical placements to promote and enhance learning and training in providing quality health care to people with cognitive disability, should be considered and scoped.

Accreditation standards

Proposition 8: review of accreditation standards

8.1 Accreditation authorities should review and revise the standards to ensure minimum competencies in providing health care with people with cognitive disability are adequately addressed.

8.2 As and when a competency framework is available, future reviews and revisions of accreditation standards should be undertaken by reference to the competency framework to ensure alignment.

Specialist medical training

Proposition 9: specialist and sub-specialist training

9.1 Medical Colleges should review the curricula for general practitioners, paediatricians, physicians (including rehabilitation physicians and emergency physicians), anaesthetists and psychiatrists to determine what further training is required by these health professionals. As and when a competency framework is developed, reviews should be undertaken by reference to the framework to ensure alignment.

9.2 Consideration should be given to need and feasibility of sub-speciality training pathways in cognitive disability.

Continuing professional development

Proposition 10: continuing professional development

Education providers should review and revise their continuing professional development standards and programs to ensure training on providing health care to people with cognitive disability is regularly available and promoted.

Proposition 11: resources

Consideration should be given to:

a. establishing a network of Centres of Excellence on Cognitive Disability, as hubs for training, education and resource.

b. developing additional or shared teaching resources to assist education providers in providing additional, appropriate training and education to health professionals.

c. strengthening and establishing opportunities for health professionals to access training and resources, including utilising primary health networks.

d. establishing a national online repository, available to all health professionals, to hold information, training resources and evidence-based tools regarding providing health care to people with cognitive disability.

Appendix C: Witnesses

Witnesses gave their evidence in the public hearing in the following order.

Day 1 – 15 December 2020

Panel 1

Name	Organisation	Exhibit number of statement	Transcript reference
Dr Jane Tracy	Centre for Developmental Disability Health, Victoria	10-3	P-9–34
Professor Gary Velan	University of New South Wales	10-12	P-9–34
Professor Rosalind Bull	University of Tasmania	10-13	P-9–34
Professor Michelle Leech	Monash University	10-17	P-9–34

Individual witness Corey Burke gave pre-recorded evidence on 15 December 2020 before the second panel.

Name	Organisation	Exhibit number of statement	Transcript reference
Corey Burke	n/a	10-1	P-37–40

Panel 2

Name	Organisation	Exhibit number of statement	Transcript reference
Associate Professor Nathan John Wilson	Professional Association of Nurses in Developmental Disability Australia	10-36	P-40–62
Professor Chris Brebner	Flinders University	10-19	P-40–62
Liza Edwards	Council of Deans of Nursing and Midwifery	10-20	P-40–62
Dr Margaret Gatling	Australian Nursing and Midwifery Accreditation Council	10-29	P-40–62

Panel 3

Name	Organisation	Exhibit number of statement	Transcript reference
Dr Dinesh Palipana	Medical practitioner		P-67–88
Theanne Walters	Australian Medical Council	10-30	P-67–88
Professor Richard Murray	Medical Deans of Australia and New Zealand	10-22	P-67–88
Professor Inam Haq	University of Sydney	10-11	P-67–88

Day 2 – 16 December 2020

Individual witnesses Toni and Joshua Mitchell gave evidence on 16 December 2020 before the fourth panel.

Name	Organisation	Exhibit number of statement	Transcript reference
Toni Mitchell	n/a	n/a	P-92–98
Joshua Mitchell	n/a	n/a	P-92–98

Panel 4

Name	Organisation	Exhibit number of statement	Transcript reference
Dr Jacqueline Small	Royal Australasian College of Physicians	10-8	P-101–119
Associate Professor Mitra Guha	Royal Australasian College of Physicians	10-8	P-101–119
Associate Professor Beth Kotze	Royal Australian and New Zealand College of Psychiatrists	10-7	P-101–119

Individual witness Virginia Howie gave evidence on 16 December 2020 before the fifth panel.

Name	Organisation	Exhibit number of statement	Transcript reference
Virginia Howie		10-4	P-120–126

Panel 5

Name	Organisation	Exhibit number of statement	Transcript reference
Dr John Bonning	Australasian College of Emergency Medicine	10-6	P-129–144
Associate Professor Leonie Watterson	Australian New Zealand College of Anaesthetists	10-5	P-129–144
Adjunct Professor Annette Solman	Health Education and Training Institute	10-38	P-129–144

Individual witness Laura Naing gave pre-recorded evidence on 16 December 2020 before the sixth panel.

Name	Organisation	Exhibit number of statement	Transcript reference
Laura Naing	Council for Intellectual Disability		P-146–148

Panel 6

Name	Organisation	Exhibit number of statement	Transcript reference
Dr Brendan Goodger	Central and Eastern Sydney Public Health Network	10-37	P-148–165
Dr Larissa Roeske	Royal Australian College of General Practitioners	10-9	P-148–165
Dr Sarah Chalmers	Australian College of Rural and Remote Medicine	10-10	P-148–165

Individual witness Professor Julian Trollor gave evidence on 16 December 2020 after the sixth panel.

Name	Organisation	Exhibit number of statement	Transcript reference
Professor Julian Trollor		n/a	P-165–182

Day 3 – 2 March 2021

Individual witness Claire Hewat gave evidence on 2 March 2021 before the seventh panel.

Name	Organisation	Exhibit number of statement	Transcript reference
Claire Hewat	Allied Health Professions Australia	10-94	P-190–202

Panel 7

Name	Organisation	Exhibit number of statement	Transcript reference
Gail Mulcair	Speech Pathology Australia	10-95	P-205–220
Amy Fitzpatrick	Speech Pathology Australia	n/a	P-205–220
Stacey Baldac	Speech Pathology Australia	n/a	P-205–220

Panel 8

Name	Organisation	Exhibit number of statement	Transcript reference
Bronwyn Clark	Australian Pharmacy Council	10-31	P-223–238
Grant Martin	Australian Association of Consultant Pharmacy	10-34	P-223–238
Brett Simmonds	Pharmacy Board of Australia	10-26	P-223–238
Professor Bruce Abernethy	University of Queensland	10-92	P-223–238

Panel 9

Name	Organisation	Exhibit number of statement	Transcript reference
Michael Carpenter	Australian Psychology Accreditation	10-32	P-239–255
Rachel Phillips	Psychology Board of Australia	10-27	P-239–255
Dr Zena Burgess	Australian Psychological Society	10-35	P-239–255

Panel 10

Name	Organisation	Exhibit number of statement	Transcript reference
Professor Hien Ngo	University of Western Australia	10-16	P-257–276
Professor Robert Love	Australasian Council of Dental Schools	10-21	P-257–276
Narelle Mills	Australian Dental Council	10-28	P-257–276
Dr Mark Hutton	Australian Dental Association	10-33	P-257–276

Individual witness Simon Cotterell was the final witness on 2 March 2021.

Name	Organisation	Exhibit number of statement	Transcript reference
Simon Cotterell	Australian Government Department of Health	10-102	P-276–291

Appendix D: Link to transcripts and exhibits

The transcripts and exhibits tendered in Public hearing 10 are available here:
https://disability.royalcommission.gov.au/public-hearings/public-hearing-10

Appendix E: Acronyms and abbreviations

Acronym or abbreviation	Expansion
ACEM	Australasian College of Emergency Medicine
ACRRM	Australian College of Rural and Remote Medicine
AMC	Australian Medical Council
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANZCA	Australian and New Zealand College of Anaesthetists
AHPRA	Australian Health Practitioner Regulation Agency
APS	Australian Psychological Society
ATSI Framework	Aboriginal and Torres Strait Islander Health Curriculum Framework
CPD	Continuing Professional Development
Chair	The Honourable Ronald Sackville AO QC
COAG	Council of Australian Governments
Colleges	Specialist medical colleges
COVID-19	Coronavirus disease 2019
CRPD	*Convention on the Rights of Persons with Disabilities*
Cth	Commonwealth
GP	General practitioner
Manual	*Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals*
MDANZ	Medical Deans Australia and New Zealand
National Law	*Health Practitioner Regulation National Law Act 2009*
National Scheme	National Registration and Accreditation Scheme for health practitioners
NDIS	National Disability Insurance Scheme

Acronym or abbreviation	Expansion
PANDDA	Professional Association of Nurses in Developmental Disability Australia Inc.
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
UNSW	University of New South Wales

Royal Commission
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