TRANSCRIPT

PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Pandemic Orders

Melbourne—Friday, 29 April 2022

MEMBERS

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Mr Jeff Bourman (Deputy Chair)
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Ms Georgie Crozier
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Ms Emma Kealy
Ms Harriet Shing
Ms Vicki Ward
Mr Kim Wells

WITNESSES *(via videoconference)*

Dr Kerryn Rubin, Fellow Member, Victorian Branch Committee, Royal Australian and New Zealand College of Psychiatrists; and

Ms Tegan Carrison, Executive Director, and

Ms Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc.

The CHAIR: All evidence taken by this committee is protected by parliamentary privilege. Comments repeated outside this hearing, including on social media, may not be protected by this privilege.

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I welcome our witnesses here today. Thank you very much for attending to provide evidence to the committee on this important topic.

I would ask that representatives from each of the organisations, if they wish, give a 5-minute presentation, and then we will move to questions of probably about 8 minutes each among the committee members. Thank you. Perhaps the Royal Australian and New Zealand College of Psychiatrists, so Dr Kerryn Rubin, would like to go first.

Dr RUBIN: Thank you very much. My name is Kerryn Rubin. I am here representing the Royal Australian and New Zealand College of Psychiatrists. I am the immediate past chair of the Victorian branch of the college of psychiatry and was the chair during much of the early COVID period. I am also the clinical director of mental health services at Peninsula Health. I am a psychiatrist, obviously, and am here representing the perspective of psychiatry.

In terms of pandemic orders, the college of psychiatry has had a relatively balanced view of orders, which has been why we have largely not had much to say about them other than recognising that we have had some really complex needs that have had to be balanced during this period. What we have learned through this pandemic particularly is that a lot of early decisions which were made on the available evidence were made primarily focusing on people's physical health, and it was only as the pandemic progressed that the broader conversation turned to recognising the impacts that the pandemic was having on people's mental health and recognising that we actually had to look at health as a whole concept rather than simply looking at people who were infected with COVID and, really concerningly, people who were becoming very unwell and people dying. However, a lot of the information that was necessary to make these complex balances of various risks was not available at the time because we have never had a situation like this where we had responded in this manner before, so it was really hard to know what the outcomes would be other than making predictions based on previous situations which were dissimilar but had some similarities. What we do know is that the COVID-19 crisis heightened all of the risk factors that we generally associate with poor mental health. These include financial insecurity, unemployment, fear and things that we would consider to be protective factors: employment, educational engagement, access to physical exercise, daily routines, social connectedness. These things were the things that disappeared when people were placed into isolation.

What we were surprised by were the differential impacts that this had on different parts of our community. There were predictions that some of the impacts that we may see were an increase in suicide rates, and this did not appear to happen. But what we did see was a marked increase in the presentation of young people to our emergency departments, with increases not just in self-harm and suicidal ideation but in the severity of a lot of those presentations with young people. We saw an increase in presentation to public mental health services, primarily with young people with eating disorders, and we saw that often the severity of the presentations was increasing as well. So even at times where the numbers had not gone up, based on the scales of severity that are used in the emergency department triages, we saw things were getting worse for people. Again, we cannot say how much of that is simply due to being within the pandemic, how much of that was due to some of the impacts of those orders, but what we do know is that any future action will have to really take account of the significant impact that was had on some of those groups.

The other group who probably got less attention often were older people, particularly older people in residential care. Residential care facilities essentially were just shut for much of the last two years, and it was particularly difficult for people's relatives to visit, particularly difficult for people to maintain any sense of connection to the world outside, and this had particular impacts within that group.

At the same time it is worth acknowledging that there are, certainly anecdotally, a large number of people now—and we are collecting the figures around us at the moment—who actually reported difficulties as those pandemic orders have disappeared, as we are no longer having periods of isolation, in actually returning back to their previous environments. At this point anecdotally it appears that some of the people who particularly are struggling are people with anxiety disorders, who often found that being at home for prolonged periods allowed them to not be in contact with the things that were making them anxious; young people who have got social skills difficulties or autism spectrum disorders, again who have found change to be really difficult and who have got used to the situation the way it was, are now really struggling to accommodate to another change in their circumstances.

So I guess as a college our feelings are that really any future similar actions need to take a much broader view of the community and recognise that all of these changes have an impact on the mental health and wellbeing of people in our community. What I do not wish to downplay are the impacts that having not taken this action would have had—if we consider if we had had 10 times the death rate, the impact that would have had on grief, social cohesion, people potentially growing up having lost one or both parents, people losing close family members. All of these things also have a significant impact on people's mental health.

The final thing I want to talk about is the impact that the pandemic has had on our public health services and particularly on our mental health workforce. We need to recognise that not only were all of the people who work in those services affected in the same way that the general community was but while the pandemic orders may have allowed them to keep working, it was to allow them to keep working in situations that were considered to be particularly high risk, and so they were often working in situations where their own fear and anxiety, or fear and anxiety for the impact that getting COVID would have on their families, were significantly amplified. They were also often working longer hours to cover shifts, and particularly at times of outbreak people were often working double shifts to cover the large number of people who were placed into isolation as close contacts or people who actively had COVID. What we have seen is this resulting in some really significant impacts on our frontline health workers, on their mental health. This is flowing through to seeing a number of people either considering leaving or actively leaving health care at this point as we come out of this immediate pandemic phase.

I am aware you asked me to keep it to 5 minutes, so those were the key things that I really wanted to highlight on behalf of the college of psychiatry. Really happy to answer any questions further on.

The CHAIR: Thank you for that. Perhaps if we move to Amanda—I think it is—or Tegan for the 5-minute presentation. I am not sure which one is doing it. Tegan. Thank you.

Ms CARRISON: Hello. Thank you so much for the wonderful opening statement from Kerryn and thank you for the opportunity to speak with you today. I was furiously typing because I do not want to duplicate what Kerryn has already spoken very well about and much of which we completely agree with.

My name is Tegan Carrison, and I am the Executive Director of the Australian Association of Psychologists. I would like to acknowledge the traditional custodians of the lands on which we meet and pay my respects to elders past, present and emerging. I extend that respect to the First Nations people watching or participating in this hearing.

The Australian Association of Psychologists is a national peak body, and I am here today representing psychologists, who make up the largest mental health workforce in the country. Psychologists have been on the front line during this pandemic. COVID-19 has resulted in a perfect storm of conditions to push an already underfunded and overworked mental health care system to crisis point. I would like to take the opportunity to provide some perspectives from our members from a survey of private practice psychologists in November 2021. All information is Victoria specific and includes the perspectives of over 200 Victorian psychologists.

Eighty-four per cent of respondents reported an increase in demand for their services from the same time in the previous year. This is on top of a 79 per cent increase in 2020. At the time of the survey 45 per cent of

Victorian psychologists were unable to accept new clients. Of those who were able to accept new clients, 55 per cent had a waiting list. Approximately 40 per cent had a waiting list longer than six to eight weeks. It is common for clients to have to wait longer than six months to see a psychologist, particularly in regional areas. Forty-nine per cent of psychologists were working more than the previous year. This is on top of a 59 per cent increase in work hours in 2020 from pre-pandemic levels. We are concerned about workforce burnout.

Respondents reported that 61 per cent of clients required more sessions than at the same time last year; 82 per cent reported that clients were exhibiting more distress, anxiety or depression than at the same time last year. These are unprecedented figures.

I just want to mention the standard session fee. The average fee for a standard session to see a private practice psychologist was $175. Keep in mind the current Medicare rebate available to clients of 70 per cent of psychologists is only $88. This creates a barrier for those who cannot afford out-of-pocket expenses. Seventy-five per cent of respondents would be able to bulk-bill more clients if the Medicare rebate was raised to $150, which is one of AAPI's key recommendations. When we asked our members what were the most important things government could do to support private practice psychologists or improve access to clients, the number one answer was to increase the Medicare rebate for clients.

I will end my opening statement by briefly outlining AAPI's recommended solutions. So one unintended consequence of the restrictions put in place is that there has been a reduction in screening and early intervention. The reduction in face-to-face services has likely led to missed diagnoses. In the case of learning disorders in children, assessment and diagnosis has been severely delayed, meaning that children now do not have access to the services and accommodations that they require in order to do well. Disengagement from school has occurred for those with mental health conditions and disabilities, and schools lack the capacity to adequately address this due to lack of funded psychology and inclusion support for mental health.

As an industry we urgently need priority funding so that assessments can be caught up without significant financial cost to families. We urgently need to increase the Medicare rebate. A recommended amount is $150. There needs to be more funding and support for regional, rural and remote psychologists. They are asking for the same incentives as those available to GPs. We need innovation in the sector to immediately cope with the considerable workforce shortages. Establishing a provisional psychologist Medicare rebate would allow around 6000 provisional psychologists who are in the last stages of supervised practice to provide urgently needed services, significantly boosting the workforce. We absolutely need more psychologists in schools. We need to create permanent Medicare item numbers for widescale disasters similar to those established for the bushfire recovery that enabled up to 10 Medicare-rebated sessions to see a psychologist without a referral or mental health diagnosis. We also need to increase the pipeline for future psychologists by drastically increasing government-funded university places for psychology. Thank you.

The CHAIR: Tegan, thank you so much for clearly setting out all the things you need and the background to it—it certainly backs up a lot of the evidence that we have heard. I will ask the first question, perhaps going to you first of all, Dr Rubin, but, Tegan, for you to comment should you want to add to it. We have heard today that the pandemic has had an effect on all Victorians, but there can be no doubt that some groups have been more affected than others, and I am just wondering whether, Doctor, you could talk about perhaps the impacts of geography, demographics and even socio-economic issues in relation to how that has played out.

Dr RUBIN: Yes, certainly. And it is actually a complex issue. It is easy to focus on the negatives, but one of the positives that has actually come out of this has been the increased access to telehealth. What we actually hear from people often in rural and remote areas is that previously they could not access anything; now there may be long waiting lists but it is actually easier to access somebody via telehealth. And certainly I had not come along here with an agenda around Medicare items, but I actually think I really support the AAPI around this in that these are some of the equity issues that exist in our system, and as a college we have been pushing very hard for those telehealth items to remain on Medicare long term. These should not be part of a pandemic response but actually part of a way of getting equitable health resources to our rural and remote communities long term.

So having said that, what we do know is that there are particular groups. As I said, the surprise was not just the impact on young people, but the other thing about young people was that they were actually one of the groups who found telehealth to be the least useful. They often said that they would much prefer to be seeing people

face to face and were often disengaged by telehealth. What we did see is that people who were not able to engage with telehealth were therefore more likely to miss out on the services that did exist, completely supporting everything Tegan said about how difficult it is to access services and how it has really amplified pre-existing problems.

There are some other groups who have particularly struggled. People with disabilities and people on the NDIS often had significant care arrangements in place which aided them in maintaining social contact, getting to appointments and looking after their day-to-day needs. These were often significantly disrupted when those arrangements were either withdrawn because they were viewed to be not COVID-safe—meeting people face to face in close circumstances—or disrupted by people's care facilities not allowing people in or disrupted by people getting COVID and therefore not being able to receive the supports that they usually did. So this was a group who were particularly affected, and we saw that a lot of the public hospital end, where a lot of people who had previously been managed in the community were deteriorating due to lack of previously available supports.

Other significantly at-risk groups included asylum seekers, and we cannot forget this group of people, who were already an at-risk group, seeing that this whole situation seemed to significantly deteriorate their situation, particularly recognising that we are talking about people who often had most of their family overseas in countries that were much worse affected by COVID than we were. So all of this fed into a large pot of stresses that they sit in day to day. Finally, the other group of people that I think we saw particularly affected by this were—and this for me is the overlap between mental health, drugs and alcohol and other issues. We certainly saw significant increases in people's substance use, and when you combine increased substance use, social isolation and increased stress—and we have to also acknowledge the significant increases in figures for domestic violence that have occurred—and when you weigh all of these different factors up, one of the things that was shown was that there was a differential increase in the effects on women versus men for mental health outcomes and that women appear to have done worse with their mental health during the pandemic.

The CHAIR: Thank you. Tegan, would you like to add to that?

Ms CARRISON: I will let my colleague Amanda respond. Thank you.

Ms CURRAN: I would also like to add that another at-risk group was families in the early perinatal and prenatal periods. There was a real withdrawal of face-to-face services, and that increased a lot of anxiety about the health and wellbeing of unborn babies, and then there were restrictions around who could access hospital settings and supports that they would be able to receive within hospital and then in the perinatal period. So we did see a lot of anxiety increase within that group. And especially when there were restrictions around being able to visit family members there was a large number of people feeling very isolated and not having great outcomes in that early period of parenthood. I would agree about disabled folk having a lot of difficulties engaging services and that telehealth is often not appropriate or accessible for people with disabilities. There is a need for some continuation of face-to-face services in a safe way for those folk. I think as well the at-risk group of young people with learning difficulties—and they are trying to learn from home, they are really doing their best, and school staff and psychologists working in schools were really working very hard to reach out to those who were having difficulties and try to make that work. But when you have got two parents working, kids doing homeschooling, it is just a recipe for people to slip through the cracks and for things not to be picked up and children not to progress as well as they should. And I think culturally and linguistically diverse individuals and Aboriginal and Torres Strait Islander people were also disproportionately affected and had a lack of culturally safe services available to them.

The CHAIR: Thank you. In relation to telehealth, I think, coming from a rural background, it can be fantastic—and I will start with you, Dr Rubin—but I think there is also a sense in which we are afraid that that may just become all that there ever will be because of the recruitment and workforce issues that we are all facing. I know our local health service in Shepparton is 80 doctors short at the moment. When you look at these sorts of figures—and across the country—the importance of having available that face-to-face contact is apparently significant given what you said about the reaction of youth. And I am just wondering, could you expand on that a bit in terms of the risks of it actually becoming overused?

Dr RUBIN: I apologise here. You will have to cut me off at some stage because you are going to get onto my favourite topic at the moment, which is the mental health workforce, and a lot of what I do in my day-to-

day role is looking at how we put into action the recommendations of the Royal Commission into Victoria's Mental Health System. For me, one of the key things that I do not think as a state we have a cohesive approach to yet is how we address the significant shortfalls in our mental health workforces. And this is across the board: this is psychiatrists, this is psychologists, this is mental health nurses and OTs, and actually we have a shortage of qualified peer support workers as well. These are the shortages we were facing and that were known and an issue prior to the pandemic, and with the increased needs we have seen a significant amplification of those shortages. The worry is that when there are shortages we have seen across the country, where there are multiple positions sitting vacant across metropolitan as well as rural health services, many people tend towards metropolitan services. The reality is that the more workforce we have, the more that workforce tends to distribute.

We as a college have been very strong advocates for looking at multiple measures to increase our workforce. The problem is that, really, to have the workforce we need, we needed to start 10 years ago. But even now it is about measures that Tegan has spoken about, including providing some access in private settings to Medicare rebates for provisional psychologists, but it is also about introducing graduate or trainee positions within public mental health services for psychologists, for OTs, for graduate nurses wishing to work in this area. It is about increasing the number of psychiatrist training places in the country—and I have to talk to psychiatrists. In Victoria alone last year I think we had roughly 30 per cent more qualified applicants to train in psychiatry than we had funded training positions within the public mental health service. So we know that there are appropriate people out there keen to train and work in these areas, but the issue is that to train as a psychiatrist you need a publicly funded position, and to train in numerous other professions you need access to a funded university place, because the full-fee-paying places are just not reasonable or affordable for the average person.

Until we are able to address those workforce shortages I think the reality is that we are always going to struggle to get people to rural areas. This was then further exaggerated in public health services across the pandemic because Victoria has relied on overseas-trained doctors for roughly 30 per cent of its doctors in public health. As the borders were shut, suddenly those floodgates were cut off. The reality is that a large number of those people who have come from overseas then go and work in rural areas because that is where the jobs are. I think the simple solution as a country—and I am aware this is not just a state issue but a federal issue as well—is that we need to train our own doctors and we need to train our own psychologists, OTs and nurses so we have adequate staff to meet the needs of our population.

The CHAIR: Thank you, Doctor. I think, even without going to Amanda or Tegan, I will have to move on, because I have taken much too much of the question time, and move to Ms Ward.

Ms WARD: Thanks, Chair. Thank you to the three of you for being with us today, and thank you for all of the work that you have done supporting your extended workforce and, by extension, the Victorian community. Thank you. We really appreciate it. I can only imagine how difficult it has been.

Coming to that point on the workforce, the health workforce has had to undertake in an extraordinary work environment an extraordinary workload. So I am interested to hear from the three of you, if you can just expand a little bit more, on the challenges we have seen within the mental health workforce in terms of working environment, their own mental health challenges and what scaffolding, what supports, can be there to support this workforce—this incredibly important workforce. I am not going to name anyone. Just jump in first.

Ms CURRAN: I think the way that things rolled out at the beginning of the pandemic, with a move to telehealth really, really quickly, took a lot of adjustment for many of our members. There was a remit that services had to be bulk-billed at the beginning, which was a major, I guess, pain point for us. It resulted in psychologists working really, really hard at the beginning.

Regarding other issues during the time, there was poor communication about what was required, what the pandemic orders meant and what each change to the pandemic orders meant for the health workforce. There was a great deal of anxiety for people, and there were confused and mixed messages about what was needed. So we provided a lot of support to members by trawling through all the legislation and orders to try and get things clear for them. So going forward that would be a point where significant work would need to be done in communication and clarity of messaging around that. Also psychologists having to turn people away is really difficult. Having large waitlists is very anxiety provoking for practitioners; we do not like to see people sitting on our waitlist while we try and move people through treatment. There is definitely a lot of work that needs to

be done to boost that workforce through the initiatives that Tegan was talking about and also what Dr Rubin was talking about. One thing that is offered for GPs is some funded mental health support through a peer-led support line, and something like that would be really beneficial for the psychology workforce as well, to try and work through that anxiety and the kind of vicarious trauma that we have experienced working through the pandemic.

I am not sure if you have any other points, Tegan.

Ms CARRISON: I just wanted to ask if we can take this aspect on notice, because we do have some wonderful information and statistics about the mental health of psychologists and those risk factors, the burnout and things like that, so I would love the opportunity to take that on notice and provide that detailed information later on.

Ms WARD: Thank you. That would be great, because it is also really interesting and useful I think to explore that idea of that borrowed trauma, if you like, that you have to carry with you, of all the people that you are trying to support and help.

Dr RUBIN: I might, if you do not mind me—

Ms WARD: Of course, Kerryn—sorry.

Dr RUBIN: I was going to say that I think in recognising approaches to workforce wellbeing we have to recognise that there were also differential approaches to people who worked in public services and people who worked in private settings. So I would actually extend my thanks to the Department of Health, which actually put in place funding for various wellbeing support programs for people who work in public health. People who work in public health also had much better access to PPE earlier on, and we know that some of the impacts on workforce wellbeing across all of the mental health services were anxieties around not having the correct PPE. I would very seriously advocate for there being equal access to PPE for people who work in private services delivering mental health care and probably physical health care as well. Certainly I know a number of private practitioners who had difficulties earlier on accessing masks who would have been willing to do face-to-face work with people if they had access to N95 masks, who had concerns about the ventilation in the buildings they were working in but had no access to anyone who could help support them to put those things in place. I realise while we cannot do that for each individual, access to universal PPE for frontline workers, to me, seems to be a simple thing that could be done around workforce mental and physical wellbeing.

What I would say is, echoing around private stuff, what worked well in the public health system was having access to reflective practice groups. I was involved in both running and evaluating some reflective spaces where all health staff, not just mental health staff—we did it for mental health and physical health—were able to attend and actually talk about their own experiences working in the pandemic, be it the vicarious trauma they were being exposed to with really unwell people, caring for people receiving palliative care who could not have family members visit, all of those vicarious traumas but also their own fears and anxieties working in that setting.

Certainly within psychiatry we have some structures set up so that those kinds of peer supervision groups happen on a regular basis for all psychiatrists. One of the other things we were able to do was put in place a specific referral line for other health workers during the pandemic where they could access bulk-billed sessions. What I would say is, as Tegan beautifully illustrated, we saw the same issue with psychiatrists as psychologists: people quickly became overwhelmed and just did not have the capacity, even though they were working longer hours, to take on that care. Again, I think we need to, at a public level, have workforce mental health and wellbeing built permanently into our systems, and I think it would certainly be worth considering mechanisms via the different speciality groups to actually put some of those supports in place. And whether that requires some additional funding or not, whether that can be done by membership fees, I think it is a really important consideration.

Ms WARD: Thank you. I am wondering whether the three of you can also then talk to what you have seen that has actually been helpful during the last two years, that has helped support workers within your respective industries. And I take on board, Tegan, your comments around the need to increase the Medicare rebate and bulk-billing and how that will support particularly those who are about to become psychologists—that 6 000-

strong workforce is quite a strong number. What have you seen in the past two years that has been actually really useful in supporting your workforce?

Ms CARRISON: I might just answer briefly. As Kerryn touched upon, providing opportunities for some of our isolated workforce—that is primarily our private practices and rural and remote workforce. We provided lots of support and peer groups that were able to guide them through the journey. We were able to provide very practical support too. We actually sourced masks for our members when they were not available in Australia. We actually sourced from overseas rapid antigen tests about a month before they were publicly available, because we wanted to provide practical solutions to our members. We provided regular individual follow-ups with all of our members to make sure that they had all the support, resources and information that they required. We are not government funded at all; we are funded by our members to do this. I was working 20-hour days, seven days a week, for the entirety of the pandemic to provide this support because we acknowledge the incredible work that each and every one of our members was doing. We need to provide that scaffolding approach so that this is available to all of our frontline mental healthcare workers.

Ms WARD: So it is that intensity of communication? But clearly the burden of that needs to be spread across more than one person so that you are not working 20 hours a day, but it is that increase in communication and linear support?

Ms CURRAN: Yes. We also saw a really big uptake in the use of our online forums and people becoming really collegiate within AAPI in forming little peer supervision groups and having regular meet-ups. Some of our board members did some fireside catch-ups and things like that that were really well taken up. Even online supports were really well received if we were not able to provide that one-on-one support.

Ms WARD: Is that something you think you will do into the future?

Ms CURRAN: Yes, absolutely.

Ms WARD: Great. Thank you.

The CHAIR: Thank you.

Dr RUBIN: The other thing I would kind of add into these things that were positive, and again I split public and private, but in the public health system there was improved cooperation and communication between the Department of Health, particularly the mental health division, and the various specialist groups. There was certainly far more transparency in communication than I have ever experienced before, and it meant that we were able to be much more responsive and flexible in our approaches. And certainly that message about better relationships with government was able to filter down to all of our members and to our workforce through various forums.

The other real positive was the shift in education and support to online forums. What we found to our surprise is that our education sessions that we had previously run and that we moved online became much better attended, and particularly when we surveyed why that attendance was better it was often that people with families who struggled to make the time to travel to and from things found it much easier to fit in when it was simply an hour online. But the other positive has been an increase in flexible work arrangements for many people, and again what we have found is that there are different groups who for various reasons have really found it beneficial to have more flexible work relationships and arrangements and that these are things that people have been really keen to see continue, even beyond this pandemic period.

Ms WARD: Thank you.

The CHAIR: Thank you. And on that note I will have to move to Ms Kealy.

Ms KEALY: Thank you very much. Thank you, all, for presenting to us today and for the great work that you and your members have undertaken over the pandemic. Firstly, maybe I can just split it up with some follow-up questions to kick off. Tegan, in the presentation that you provided you referred to—I think you gave more current figures, but I have got that 29 per cent have a wait time of more than eight weeks for new clients. What happens to clients who are on the waitlists that have been referred through? What happens in between for someone who needs that mental health support in that eight-plus weeks until they actually see somebody?

Ms CARRISON: Of course. There are varying different approaches, so it would be ideal if we were able to develop some pilot projects for some best practice.

Ms KEALY: So there is nothing at the moment, though. You are just basically waiting for your appointment to come around.

Ms CARRISON: Sure. So mental health professionals will do appropriate triage, so when they do receive that initial referral, someone that does need urgent care will be prioritised or referred on to any emergency services. But, look, it is very concerning, and it is something that as a sector I think we can do better—whether it is some online programs, whether we can utilise a peer workforce or our students or our provisional psychologists. There is more work that is needed.

Ms KEALY: Sure. Thank you for that. And just to follow on from some of your comments, Dr Rubin, you mentioned equitable access to PPE. Is that now available? Is that something that happened early on, that there was not access to PPE for mental health professionals, or are we still in the situation where there is no standard provision of PPE to mental health workers?

Dr RUBIN: I am going to make a comment that outside of the public health system there is no standard provision; everyone is responsible for their own PPE. My concern particularly was that early on—but actually at various periods as well—at times of constraint there was just no access at all for people working in the private sector. A number of the medical colleges would also have said that the access that there was within the public health sectors was not equal to the level of PPE that they felt was necessary, and then again you would always see that lag down to the private sector, where it was really an open market and a bit of a free-for-all, with some people able to access things early on, often from overseas, and other people not. Tegan mentioned access to RATs, and even at a public health level at one point when there was limited access I know that there were some services who were able to access them by private arrangements with industry, who had access to their own stores, and other services who were not. I think for me it is about that really cohesive planning. Clearly there was a lack of an appropriate stockpile. This is not said in a blaming sense. I do not actually think any of us predicted this scenario happening in this manner; though certainly if you talk to some of the public health people in the Department of Health, they have always been saying something like this is going to happen eventually. But I do not really think we were prepared for it.

Ms KEALY: And, Dr Rubin, just another point. You said that last year there were 30 per cent more trainees than funded training positions.

Dr RUBIN: Thirty per cent more applicants for psychiatry training than funded positions, yes.

Ms KEALY: How many trainees would that represent?

Dr RUBIN: I can take this on notice to give you the exact figures, but there are roughly 80 first-year training positions in Victoria and there were roughly 27 to 30 people who had applied, passed the interview to be accepted into training, but there were not enough hospital-funded training positions to place them in.

Ms KEALY: Did your college make an approach to the state government to fund more supervised positions, given that would have unlocked about 30 psychiatrists into the system when we were desperately short of workers?

Dr RUBIN: We have been making approaches on a yearly basis to government to expand those training positions for as long as I have been a member of the Victorian branch as a psychiatrist and a trainee for over a decade now. It is not about funding those first-year positions, but there are other positions that you need to train in to train as a psychiatrist, and if there are not positions available in those specialty areas, you are not able to fund a first-year position—so particularly that child and adolescent psychiatry training. Part of why we currently have a lack of child and adolescent psychiatrists in Victoria is that a lot of the advanced training positions were converted to basic training positions so we could increase the number of general psychiatrists, but to the detriment of having specialist child and adolescent ones. So the state government did fund a few additional child and adolescent training positions, which allowed us to make small increases in the number of trainees we were able to have in Victoria. But the reality is with appropriate funding, and I am hopeful that is going to come via the royal commission, we could increase the number of psychiatrists we are training by 20 to 30 per cent almost—I will not say overnight, but within 12 months.

Ms KEALY: I find it quite astonishing that there are so many psychologists that are wanting to train into the area when we have got this workforce shortage and that it is a matter of funding when there is a lot of money available and it was recommended by the royal commission back in 2019, in the interim report I believe. I cannot believe that just last year we still did not have enough training positions for those trainees, and we have not developed that youth and adolescent pathway either.

Dr RUBIN: The concern for me is that Victoria is unusual in the sense that we have a significant oversupply of people wishing to train here, because at least in Victoria our training program is considered to be one of the best in Australia. What then happens is New South Wales tends to struggle to fill their positions and that some of those people who have missed out on places in Victoria go and get a training position in New South Wales, and the majority of them never return. There are a lot of good statistics that say people tend to work where they train, which has been the basis behind trying to get more trainees into rural areas, and one thing that government has done successfully is expand the number of rural training psychiatry positions. But, again, if there were 20 additional positions, we could probably fill those tomorrow.

Ms KEALY: It sounds like a very simple fix. It is budget day next Tuesday. Watch this space, hey? Fingers crossed for you. Tegan, on a similar line, as you went through in your presentation you have been pushing quite hard for provisional psychologists to be included and be able to access Medicare, but there are other funding streams as we heard this morning as well as in your presentation. We have really got a significant workforce shortage and by not having additional workers, and I guess looking under every rock we can to find somebody to provide additional mental health support, it has actually put enormous pressure on the existing workforce who have felt overwhelmed and overstretched with the demand that we have seen through the pandemic and through restrictions. Have you approached the state government to see if there is any surge funding that might be available to provide funding support to allow supervision for those provisional psychologists so that more Victorians would be able to get some level of mental health support?

Ms CARRISON: Thanks for the question, Emma. Yes, we have directly approached the Victorian government. As of today I have not received a response.

Ms KEALY: When did you approach them?

Ms CARRISON: I would have written at least six letters over the last two years.

Ms KEALY: And you have not received a response at all in two years? That is quite damning, Tegan, but thank you very much for that. My time is up, but thank you very much for your time today and for your great advocacy and work in this area—all of you. I really appreciate what you have done.

The CHAIR: We will go now to Mr Bull.

Mr J BULL: Thanks very much, Tegan, Amanda and Kerryn. Thank you for presenting to the committee and most importantly I think for all the work that you have done over these past couple of years. If you could please pass on our thanks to all those that you work with and all staff, it would be greatly appreciated. Kerryn, I just wanted to go to some of the evidence you provided earlier, and I believe you said something along the lines of 'Don't downplay the impact if the death rate had been 10 times higher', and I think that is a really important point in the context of the conversation we are having. Can you just elaborate a little bit further on that point that you made—and perhaps, Amanda and Tegan, if you could also add some comments—in terms of the alternative approach?

We heard evidence in the previous hearing around concerns that would have been raised time and time again, and I think the evidence that was provided to the committee was this may be a debate that is going to go on forever in terms of ways that decisions could have been taken or, to the counter, may not have been taken. So, Kerryn, I just wanted to go to that. Could you just collaborate a little bit further on what the alternative might have looked like and, probably most importantly, what are the impacts on the community that we might have faced?

Dr RUBIN: Thank you very much, Mr Bull. For me the issue is that what we engage in when we engage in public health measures are large-scale risk-benefit analyses, and the real difficulties are when we do not know what the implications of some of our actions may be because we do not have the evidence to speak to that, so we then enter into extrapolation or speculation around these things.

Some of my training background is in epidemiology, so certainly I would have been one of the strong proponents early on for the need to engage in a lot of the protective measures that we did because the evidence supported those. I will also say that very early on my concerns were also that the evidence from overseas and from China was indicating that the highest death rates were in some of the most vulnerable people, and some of the figures about the deaths of people with severe mental illness in some of the institutions in China were particularly worrying. So we were actually advocating really strongly for measures that were protective of vulnerable people in our community. However, we also acknowledge that one of the things we could predict was the impact of social isolation, and this has always been a difficult balance to strike.

What do we know about the impacts of death and grief on people? We know that they are variable, but as a group one of the most significant stresses people can face is the death of an immediate relative. And particularly there is strong evidence that says when that death occurs for somebody during childhood, that is a significant adverse event during childhood, and when you add that to other adverse events during childhood that have been experienced, the more adverse events during childhood, the worse your mental health outcomes are likely to be statistically as you move through life. We also know that some of the negative impacts on mental health have been via unemployment, via the impacts on the economy. We would be extrapolating, but you would have to say that some of the figures from overseas say that even when pandemic measures were not enacted, there were significant impacts on the economy, on businesses, and that when you have significant illness and death that impacts as well. So I think this is one of those unanswerable questions about the 'what if'—'What if we'd done this? What if we'd done that?'.

What I would be strongly advocating for in future is that with any similar actions in similar circumstances or different circumstances where we also have to take a large-scale public approach to something we very actively think about what are the mental health implications, how are we going to support the workforce and how are we actually going to make certain—and this is where I think it is about preventative planning—we have the workforce available to support the mental health and physical health of our population? We had a stretched mental health service before the start. That is why we had a royal commission. All the pandemic did was illustrate all of the gaps and make them so much worse. I hope that answers your question as best as I can.

Mr J BULL: No, indeed it does. The $4 billion allocation in terms of mental health I think is a big step forward, but, as you say, there is always more work to do. Tegan or Amanda, do you want to make any comments on that question?

Ms CURRAN: I think that we would just reinforce everything that Dr Rubin has said there and that if this happened again consulting with the mental health workforce around messaging and public health initiatives would be really of great use there. When restrictions are put in place maybe during press conferences there might be some mention as to what you can do to protect your own mental health, and having some public campaigns going around—how you access the support you need and how you get support from people that are close to you et cetera—would be really helpful.

In addition to what Dr Rubin said about bereavement rates and the stress caused if we had not done what we had done, I would like to illustrate as well the significant impact of long COVID and post-infection syndromes and that we are seeing that in the community at this time. Had we not put those orders in place, I think we would have a really big public health burden of trying to work with those people and work on recovery initiatives for that group. Already it is a burden on the system, and there is not enough evidence around how to improve someone's health in that post-COVID period. So I guess that is one really big benefit of taking the action that was taken at the beginning, especially when vaccination was not as widespread in the community.

Mr J BULL: I think you are absolutely right; it is a really important point. I think we are all still learning about the impacts and the data around long COVID—to be able to go back and say, 'Well, COVID was prevented in the first place' and therefore long COVID will be prevented and what the health impacts are around that. I think it is a really, really important point.

I also wanted to ask—and feel free, any of you, to jump in—or touch on the mental health practitioners in schools program, and I wanted to just get your thoughts on that program. I know that in some introductory remarks you spoke about the impacts of mental health on young people through the pandemic. It is a really important program, something that I know local schools in my community really benefit from. I just wanted to get your views on the program: what you think the benefits are and how that works within schools.

Ms CURRAN: I think one of the major benefits of those programs is children not having to be taken outside of school settings to receive mental health support. That is a massive positive for that program. I think the workforce is still thin and much more needs to be done to roll out those programs, get the mental health workforce into schools. There are many initiatives that could be put in place on a whole-of-school level to improve health outcomes for kids, especially what we said in the opening statement around testing of educational and learning problems, and supports tailored to children would really go a long way as well.

Mr J BULL: Tegan, do you want to add to that?

Ms CARRISON: Yes, look, I would love to add to that. I actually have a detailed analysis of the Victorian program that I would love to share with you. We are a national association, so we get to compare the different jurisdictions. Victoria is doing very well in this regard and the offering, so my kudos to you for establishing that. Of course we can always do more, I think particularly in that preventative and early intervention stage. In our system as a whole, our mental healthcare system, we tend to wait for people to become unwell enough before they are seeking services. So particularly in that school setting if we can be investing in resilience and prevention and early intervention activities, that will pay off very much so from a financial perspective as well as benefiting our community.

The CHAIR: I will have to move on to our next questioner now. Thank you, Josh.

Mr J BULL: Thanks, Chair.

The CHAIR: We will move to Mr Wells.

Mr WELLS: Thanks, Chair. Maybe to Tegan or Amanda: at the start of your presentation you spoke about the waiting lists and the length of time for people waiting to see a psychologist. If the pandemic orders finish mid term, hypothetically—if they do, and we all hope they do—how long will it take for the catch-up to take place?

Ms CURRAN: That is a really difficult question.

Ms CARRISON: If I can just jump in, Amanda, I think we would just be speculating if we provided any sort of definitive answer. What we do see, though—the pandemic was a mass trauma, and we know that that has a very, very long tail. So it is not as simplistic as saying if all restrictions and pandemic orders end today, then it is going to be three months for us to catch up and fix everyone's mental health concerns.

Dr RUBIN: Sorry, I might jump in there, Tegan, because it has reinforced as well that I think you are quite right, that a lot of the models we started working off were those disaster-type models that affect large populations, but usually what you are talking about is a more conscribed incident, and even with those incidents we know that what you are looking at is one year to two years down the track—they are often those really concerning periods that you encounter. We do not have a good sense of what we are looking at after two to 2½ years. What I will say is when you add new cases that would have been occurring, of mental health difficulties independent of this, onto that already long waiting list and the lack of workforce—it is a similar situation with private psychiatrists except often books are not even open. I know even for me with all of the connections I have I might need to ring eight or 10 people before I find somebody even willing to put somebody on a waiting list. It has got that bad. I think we are looking at years of workforce development before we reach a point where people will not be waiting for a long time.

Mr WELLS: Yes, and I guess that is the point I am making—that even if it comes to the end of the pandemic there will be still people affected that may see a psychologist or psychiatrist in six months time, so the tail will continue on and on and on as a result of the pandemic.

Doctor, in regard to your presentation, you mentioned the need for mental health awareness in pandemic orders. If we had our time over again and we were going back to, say, January–February 2020, what should the pandemic orders have included in regard to mental health awareness?

Dr RUBIN: That is a really good question, and it is also a difficult question in that again my comment will be speculative because we have not done these things. It is hard to know whether they would have had the impact that we think they would have had. However, I will look to some of the things that I think in specific

examples we think were really concerning or could have been done differently, and I talk particularly about some of those hard lockdowns that occurred, particularly in the high-rise buildings—both the nature of those specific orders and the very sudden manner in which they were imposed, right down to people living in the buildings not being aware that they were under an order but seeing the police arrive, recognising that this was actually a group of people who cross-sectionally, if you look at their situations, are people who have had significant traumatic experiences, often involving police, in other countries or in Australia. The manner in which we responded to them probably heightened their own distress, fear and mental health concerns. I think then applying that thinking more broadly is recognising all of the specific groups who actually really struggled with understanding the pandemic orders and how we were able to communicate with them much earlier and we were able to put in place access to mental health supports. As I say, I think it is difficult to say how we could have done that differently, recognising that actually there was a shortage of those supports, but that is one of the things we would have liked to have seen—that message about access to supports being integral to the rolling out of those orders.

As we roll through the pandemic I think hindsight is a wonderful thing, but some people have speculated about the impact. As we were aware of the impact on younger people, once we had vaccination was there a way to get younger people back to school safely sooner? It is hard to answer that question. But I guess that certainly one of the concerns was when we identified a group where the mental health concerns for them were particularly severe, did we need to be taking targeted avenues to get some people back into school environments earlier? Those were the really big-ticket items that stood out both for me and as a representative of the college of psychiatry that came up in our discussions. I think the other things were more federal-type issues, and that was particularly around increasing access to telehealth earlier, making that more ongoing and looking at measures to make things more accessible, such as rebates. But, again, my concern is even if there had been a $500 rebate, at the end of the day there were only a finite number of staff to see a very large number of people, and that was part of the issue all along.

Mr WELLS: Thanks. I guess a question to the three of you. We spoke about recruiting professionals. Is there an issue of retaining the professionals in the profession, working extra long hours, getting burnt out and everything else? Is it becoming an issue, retaining psychologists and psychiatrists?

Ms CURRAN: Absolutely. Yes, that is a big issue that we are trying to address at our end: how we can support psychologists, how we can make their job easier so that they can stay within the workforce? But there are things that need to be put in place that are outside of our capacity to enact, especially around financial remuneration so that people can look after their own needs a lot better. We have got a reliance on, I guess, solo practitioner type services in psychology and that can create issues of isolation and lots of out-of-hours work doing compliance-related issues, like Medicare compliance, getting all your billing right, making sure money is flowing in and out. Having that additional funding there for practitioners means that some of that stuff can be outsourced to others and takes the burden away. I do not know if you have got anything else, Tegan.

Dr RUBIN: The other thing I would add is if you are recognising some of the groups—and I am going to talk particularly to public mental health and public health services—that were affected, there is some very nice evidence out there that retention within management level staff and clinical management staff has become a particular issue. Surveys have indicated, and this is across the mental health professions, that part of that has been that not only were they carrying all of their regular workplace responsibilities but they also felt a responsibility for the health and wellbeing of all of the people working for them in ways they never had before without any additional time or additional supports. I can talk on a very personal level that I would not have expected previously in my job to get calls at 2 o'clock in the morning to say, 'We think we have got a COVID outbreak. We need everyone to come in now and work out who has been a close contact, who do we need to isolate'. Over a two-year period incredible stress has been put on people in those senior positions, and what we have seen is a number of people identifying that they would either like to step back to more junior positions where they do not have the same level of responsibility, to take early retirement or to move towards potentially working in other fields, because they just feel that they have done what they can do and they are burnt out.

Mr WELLS: Thank you.

The CHAIR: Good. Thank you. And we will move to Mr Erdogan.

Mr ERDOGAN: Thank you. First of all, I would like to thank Dr Rubin and also Tegan and Amanda, who have joined us today as well, and I have really enjoyed the discussion so far. A point I want to touch is also the mental health and wellbeing of the workforce in psychology and psychiatry practices, because a consistent theme across our public hearings has been the workforce strain and also challenges—workforce shortages—across different, I guess, health professionals that have been impacted by the pandemic, but obviously probably your sector in particular has been disproportionately affected compared to others.

I want to just ask: could each of you tell us about, I guess, the mental health of workers in general and how they have been affected in psychology and psychiatry in relation to the circumstances at present? Because obviously your number one priority is always your patients, but how are your members going—of your organisations? How are they feeling? Anyone can go first—Dr Rubin or Tegan.

Ms CARRISON: I will just answer very briefly, and I am happy to take this notice because we do have statistics, data and information on this. We have surveyed our members extensively about their own health and mental health and, you know, those risk factors for burnout and mental distress, but in general the pandemic in these very challenging few years has taken a toll on the mental health and physical health of the mental health workforce—a significant toll.

Mr ERDOGAN: Thank you.

Dr RUBIN: I will take it on notice around the specific figures because I am actually aware of a national survey that has been done, looking at psychiatrists and psychiatry trainees, by St Vincent's Hospital in Sydney. Their data is due out soon. But I would just echo what Tegan said. We have certainly seen it taking a significant toll, and there have been a few different organisations that have actually been set up specifically to help address the impacts of this on the physical and mental health workforces.

Mr ERDOGAN: Excellent to hear that actually. That was my kind of follow-up question that I was going to ask: have there been any new initiatives that have come up that you have seen assist the workforce? Do you have any ideas of supports or interventions that we as a committee could take on board?

Ms CURRAN: There are a few that I know of. There is the Hand-n-Hand program that provides peer-led intervention for the health workforce. There are some other sort of informal groups through Facebook and that sort of thing as well, where people can hop on and ask for support. During one stage of the pandemic there was a help-the-helper kind of informal initiative that was rolled out on a community level; I do not know how widespread that one was.

Mr ERDOGAN: Thanks for that, Amanda.

Dr RUBIN: Actually I was particularly going to call out Hand-n-Hand, which, for people who are not familiar with it, stands for helping Australian and New Zealand nurses and doctors. It was actually started by a psychiatry trainee in Queensland, and it is now rolled out right across Australia and New Zealand. They have been able to attract both private and government funding to help support their organisation, and I really just want to thank and congratulate them for the amazing work that they have been doing.

Mr ERDOGAN: That is fantastic to hear—an Australian initiative that has gone across the Tasman. I did have one final question, just about the psychology and psychiatry field. Have you noticed if there has been greater interest in the profession from young people wanting to study and have a pathway into the profession since the pandemic? Has there been a negative effect or a positive effect in terms of the broader interest?

Ms CURRAN: I am not sure that we have got data on that one. We have got some unique problems in psychology, where there are bottlenecks through our training system, where lots of people start in the undergraduate level but do not necessarily make it through to the other end to gain a qualification that would allow registration. So I think there has generally been quite a good uptake of psychology at an undergraduate level, but financial barriers and university placement barriers are preventing that workforce from growing adequately. And it sounds like the same issues are present in psychiatry.

Mr ERDOGAN: It is a good point you have made, Amanda, because it is a common theme I have heard as well. One of my cousins has her own private practice, and she explained to me the pathway, which obviously I was not familiar with. It seems you do the undergraduate degree with FEE-HELP, but then there is this kind of

masters-type program which is quite expensive and can sometimes lead to six-figure sums to finish your qualification—to get qualified. Is that something that maybe the commonwealth could probably address as part of that FEE-HELP? I do not know how you do it, because there is clearly a need, and that bottleneck is something that I consistently hear about from people in the sector, especially, like I said, from my cousin who has her own private clinic, who tells me how it can cost hundreds of thousands of dollars by the time you complete your qualification and are able to work in the field. Is that right?

Ms CURRAN: Yes. The shortest route to registration, the 5 plus 1, I think is around $35 000 for that one year at university. So you do the undergraduate and then honours, which are FEE-HELP enabled, and then you have got the $35 000 for the next one-year masters. And the two-year masters costs much more than that. I think—sorry, I have just lost my train of thought just there—there is workforce reform going on within the psychology profession from the regulatory body, so there will be some changes in this area. I am not sure exactly what those are, but my understanding is they are trying to remove some of those bottlenecks and get people work ready and sort of create more of a flow across the different courses that you need.

Mr ERDOGAN: Thank you. That is all from me, Chair.

The CHAIR: Thank you. We will go now to Ms Shing, finally.

Ms SHING: Thank you very much, Chair. It is unlike you to allow me to have the last word in these hearings. I do appreciate your latitude on a Friday afternoon. Thank you, everybody, for attending and for providing your very specific insight into the consequences and impacts of the pandemic upon the people who you work with and also on the clients, consumers and patients who you provide care and expertise to. It is an enormously heavy burden that everyone has borne throughout the course of the pandemic, everyone from orderlies and cleaners in our hospital system through to people who stack our supermarket shelves and drive our trucks. It sounds very much to me as though the challenges, the exhaustion, the grief, the fatigue and the frustration that you are feeling are pretty universal—not just to Victoria either but to other parts of the country and indeed globally.

What I want to do with the limited time I have available is to pick up on a number of the themes that have come out in your presentation today around workforce strategy and development. You would be aware that we did release the workforce strategy for mental health last year. That was a $41 million investment I think on top of the $235 million-odd that we invested into pandemic response at the outset. Now, that was, as you will recall, a recommendation from the royal commission, and it is about providing that pipeline, Amanda, that you referred to and also Tegan and Dr Rubin touched on as well. That is about refreshing a plan every two to three years as the strategy evolves. I would like to get a sense from you of your reflections on the first iteration of that workforce strategy and, more broadly, what we need to do to constantly address those very issues of pipelines, of retention and of wellbeing that I and indeed others have touched on in the course of today's hearings. Why don't you go first, Amanda, and then Dr Rubin and perhaps Tegan to finish up after that?

Ms CURRAN: Tegan is probably more across the implementation and details of that plan.

Ms SHING: Sure, yes.

Ms CURRAN: But I think there have been improvements, but perhaps it is not exactly where it needs to be just yet and the information has been a little bit patchy.

Ms CARRISON: Look, I am relying on my memory of my thoughts on that workforce strategy. When I first read it my initial thoughts were that it does have some really good bones to it. It does have some really good concepts for psychology as a profession. I did not see enough specific, because as with, I am sure, all professions, there are some very unique challenges to psychology as a profession, particularly this bottleneck issue. We have huge demand in the community for people to become a psychologist and to study psychology, yet the pathway is very convoluted and there are lots of different barriers. My perspective on the workforce strategy is I understood what it was trying to achieve, but from a psychology perspective it just did not go quite far enough for discipline-specific measures.

Ms SHING: That is then something that will be refreshed every two to three years. I would hope that this idea of continuous improvement and refinement as we work our way through pandemic response and what recovery looks like will be a part of something that you will be contributing to. That is obviously really

important from that perspective. I am going to come back shortly to talk about pipeline and work particularly with JMOs. But, Dr Rubin, what would you like to add to that question that I have just asked?

Dr RUBIN: Look, maybe I am going to answer your question before you ask it then, Harriet—

Ms SHING: Excellent—let us segue.

Dr RUBIN: about the pipeline and the JMOs, because that has been the primary strategy that has been put in place so far post royal commission with looking at mental health upskilling within doctors and a potential pipeline towards psychiatrists. So far the first two iterations of that—an initial small intake two years ago and a much larger intake this year into those JMO positions. For people not aware, JMOs are junior medical officers. It is usually doctors, either interns, so first-year graduates, or HMO 2s or 3s, which are second- and third-year medical officers doing junior positions working within mental health services where there is a significant training component. There is a curriculum that was put together by consultation by the Department of Health. The idea is that people will do a three-month rotation working in a mental health unit and improve their mental health skills, not necessarily to ever go and work in mental health but as doctors to improve the overall skill level of all doctors so that when somebody goes and sees a GP, a surgeon—whoever the doctor is—that doctor both has a better understanding of mental health issues and is better able to recognise when they are impacting on the person in front of them, make an appropriate referral or is able to put in place in-call treatment options without having to access help from someone else.

The initial feedback from that so far has been excellent. It has been really well received by the doctors, many of whom have described it as one of the best rotations or positions that they have done in their first two years. What we are now starting to see as a flow-through from that is a number of those doctors are looking to apply to train as psychiatrists as well. The overseas evidence indicates that when you offer these opportunities roughly one in four people who take up these opportunities attempt to train in psychiatry afterwards.

The main issue we have is we have not seen that expansion of the training positions. There was some implementation of the additional child and adolescent positions. By the time the funding came through all the positions across the state in other jobs had already been advertised and filled, so it was then difficult to fill the positions because the workforce who would want to take those positions would actually have to resign from a job that they had just accepted to fill those positions. So there were some technical issues.

Ms SHING: Yes, initial challenges in relation to the rollout and implementation. I just want to ask, again to pick up on a number of themes that have been raised today, where is your advocacy going with the commonwealth government around those educational supports, working with the tertiary sector and the access to study and career pathways through that sector as well as those immigration pathways? We have talked about importing the workforce and how that might be used to supplement existing shortfalls and also access for provisional and trainee workers to contribute to the sector. I think that is a really important part of our conversation about the distinction between state and commonwealth jurisdictions. So leap in in whatever order you would like, and I will put myself on mute.

I am taking myself off mute to perhaps nominate you, Tegan, to answer that question first, followed by Amanda and then Dr Rubin, if that is all right.

Ms CARRISON: We are all trying to be very polite. I would love to answer this question. In short, our advocacy is ongoing. Many of the changes that we need to occur are at a federal level. We believe that these are urgent issues. Obviously at an industry level there is that level of frustration because we know how urgently these measures and these changes and reforms are required.

Ms SHING: Well, they hold all the levers, don't they? I mean, that is what we are looking at in reality.

Ms CARRISON: Yes. A lot of them are federal issues. We are very, very happy to partner with states, though, particularly on piloting of projects so that we can, once again, build our evidence base on what we believe will work. So there are certainly opportunities at a state-based level, but a lot of changes will need to occur at a federal level.

Ms SHING: All right. There is an election coming up. Hopefully we will get something that we need from that to assist. Dr Rubin and then Amanda, you can have the very, very last words.

Dr RUBIN: I am going to speak to issues around recruiting people from overseas. I think one of the things that we have to acknowledge is that there is actually a WHO code of conduct around recruiting health professionals from less developed countries to countries like Australia. There are actually significant ethical issues when frequently we seek to attract health professionals from countries with even greater deficits and more needs than we do. That being said, I will be the first person to say I do everything I can to attract health professionals from countries like the UK. This is not discriminating against developing countries, and I think we accept anyone on their merits. But I do think we actually have an obligation to train our own health professionals. We are a wealthy country. We should be an exporter of health services, not an importer.

Ms SHING: That is an argument for the university sector to perhaps be better resourced. All right. Thank you for that. And Amanda?

Ms CURRAN: Hi. I think that we advocate as much as we can and get involved in as many consultations and submit evidence to government all the time. So we are working where we can, but it takes the other party to meet us halfway.

Ms SHING: Federal campaign.

Ms CURRAN: Yes.

Ms SHING: I am going to put myself definitely—permanently—on mute now. Thank you very much for that, and back to you, Chair.

The CHAIR: Thank you. Thank you to our witnesses for appearing today, especially this late on a Friday. We really appreciate the fact that you have taken the time to answer all our questions, and it is important evidence. It helps all of us to come together to report on these issues later on to the Parliament. Thank you again. You will receive a transcript of the hearing for you each to review and ultimately that will go on the website. That concludes today's hearings, and I thank everyone again for the evidence they have provided.

Committee adjourned.