

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room,
90-130 Swanston Street,
Melbourne, Victoria

On Friday, 5 July 2019 at 10.00am

(Day 4)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols SC
Ms Fiona Batten
Ms Georgina Coghlan

1 MS COGHLAN: Good morning, Chair and Commissioners. Today
2 we are continuing on with the topic of prevention and early
3 intervention.
4

5 As Lisa Nichols identified yesterday, a key challenge
6 for the Commission is to identify evidence-based prevention
7 and early intervention approaches to consider how they
8 could be implemented in ways that are sustainable and
9 effective, reaching those in greatest need.
10

11 There will be a number of witnesses called today. The
12 first is Amelia Morris who's a 21-year-old young woman and
13 consumer. After that, you'll hear from Dr Gaynor Blankley
14 who is a specialist in perinatal care.
15

16 But, before hearing from Dr Gaynor Blankley, you will
17 hear from Shaun McClare who is a principal at Kalinda
18 Primary School, and he will give evidence about Positive
19 Education and the impact it has had at the school where he
20 is the principal.
21

22 You will also hear from Dr Ric Haslam who is the
23 Director of mental health at the Royal Children's Hospital.
24 He will give evidence about the current infrastructure for
25 youth mental health services within the hospital context
26 and he will also address the difficulties in access for
27 children and young people.
28

29 Finally, this afternoon, you will hear from Professor
30 Pat McGorry. He is the professor of youth mental health at
31 the University of Melbourne and Executive Director at
32 Orygen, the National Centre of Excellence in Youth Mental
33 Health.
34

35 He will give evidence about the many issues facing the
36 mental health system and will opine about the elements he
37 sees as critical to a well functioning mental health
38 system.
39

40 I propose to call the first witness now. I call
41 Amelia Morris.
42

43 **<AMELIA JANE MORRIS, affirmed and examined: [10.03am]**
44

45 MS COGHLAN: Q. Just make yourself comfortable, Amelia,
46 make sure we can hear you in the microphone. Now, you've
47 provided a statement to the Commission in relation to your

1 experience?

2 A. Yes, I have.

3

4 Q. I tender that statement. [WIT.0001.0005.0001] You are
5 currently 21 years of age?

6 A. Yes.

7

8 Q. You live in Melbourne, but you grew up and went to
9 school in country Victoria?

10 A. Yes.

11

12 Q. Can you tell the Commissioners about, really, your
13 first experiences in relation to any mental health issues
14 you might have had?

15 A. Yep. So, I've been diagnosed with major depressive
16 disorder, generalised anxiety disorder, and comorbid
17 attention deficit hyperactivity disorder. When I was 11 or
18 12, I started to become withdrawn, I kind of withdrew from
19 things I'd previously enjoyed, like hanging out with
20 friends. I spent a lot of time in my room when I was home,
21 I didn't spend time with my family which was a real change
22 to how I'd been before.

23

24 A lot of those changes were kind of dismissed by
25 people around me as puberty and hormones, and so, it wasn't
26 until I was 16 in 2015 that I kind of realised something
27 was wrong and I shouldn't be feeling like this, so I spoke
28 to my mum to try and get some support for my mental health;
29 that was in January 2015.

30

31 Q. Where did you go then for that initial support?

32 A. So, I first saw my local GP and, very soon after that,
33 I also started having appointments at Headspace; so, I was
34 seeing them both kind of simultaneously.

35

36 Q. How did you select the GP that you saw?

37 A. The GP was kind of locally acknowledged as the expert
38 in mental health in the town; so, he was who my mum thought
39 would probably be good for me to see.

40

41 Q. What assistance did you get from the GP at that time?

42 A. I was initially diagnosed with anxiety, which I didn't
43 feel was right and later was given a different diagnosis,
44 which is my current diagnosis. He was reluctant to put me
45 on any sort of medication even though I'd expressed a
46 desire to try because I didn't feel the talking therapy I
47 was having at Headspace was helping me very much.

1
2 He told me to try an online anti-anxiety course and,
3 when I tried to sign up for it, it wouldn't let me because
4 you had to be over 18 years to use it and, when I told the
5 doctor this, he told me to lie about my age.

6
7 Q. And, you were 16 at that time?

8 A. Yes.

9
10 Q. Was it at that stage that you had a feeling like, is
11 this it, is this all there is?

12 A. Yeah, I felt quite hopeless and it really felt like
13 there wasn't really any sort of help there, because there
14 wasn't really any other kind of solution offered by the GP.

15
16 Q. Can I ask you a bit more about Headspace. You
17 mentioned that you effectively were seeing someone at
18 Headspace at the same time as seeing the GP?

19 A. Yep. So, I was seeing a psychologist at Headspace,
20 and we were doing a lot of talking therapy, which I didn't
21 feel was helpful.

22
23 I also saw a psychiatrist at Headspace who did end up
24 putting me on some medication. Unfortunately, I really
25 wasn't getting any better. I kind of reached the halfway
26 point of the ten Medicare subsidised sessions and I was
27 really beginning to worry about what I would do afterwards
28 because I wasn't improving at all, and I was already
29 halfway through, so I really, really was stressing about
30 what was going to happen at the end, how we were going to
31 kind of afford it; the burden on my family.

32
33 My psychiatrist also ended up going on emergency
34 leave, which really sucked for me because I really liked
35 him and I felt very validated by him, but he had a family
36 emergency and had to go, so I couldn't see him any more.
37 And, I was having some suicidal thoughts that weren't going
38 away. I had disclosed those to the psychologist and the
39 psychiatrist and they were helping - trying to help me
40 manage those, but I really wasn't getting any better.

41
42 Q. I'll come back to that just in a moment. You talked
43 about the perceived burden this had on your family. Just
44 in terms of getting to and from the Headspace, how easy was
45 that for you or how difficult?

46 A. It was very difficult. So, the Headspace was a 40, 45
47 minute drive away. There was no kind of public transport

1 link for me to use, and obviously, because I was 16 I
2 didn't have my own licence, so my mum had to drive to
3 school, pick me up, take me to the appointment 40 minutes
4 away, wait for me to finish, drive me back to school and
5 then drive herself back to work.

6
7 So, it ended up being probably a two hour round trip
8 for her, which was really, really difficult. She was a
9 single parent; I have two other sisters, so having to do
10 that once a fortnight was a really big burden on her.

11
12 Q. And it meant you missed out on about a half a day of
13 school once a fortnight as well?

14 A. Yeah, I was very stressed because of school, and so,
15 I'd go to Headspace to help me manage that stress, but
16 unfortunately it meant I missed more school, became more
17 stressed, and it was a bit of a vicious cycle.

18
19 Q. You mentioned your siblings, they were 13 and 15 at
20 the time?

21 A. Yes, they were.

22
23 Q. Can I ask you about a point in time in June 2015?

24 A. Yeah. So, I had my Year 11 exams coming up which at
25 the time was a really big stress for me, and I wasn't
26 getting any better with the help from Headspace and my GP,
27 the sessions were starting to run out, and I just wasn't
28 getting any better.

29
30 And then one day I came home from school and I
31 attempted suicide. I ended up calling the ambulance myself
32 because I saw my dog and I thought, "What are you gonna do
33 without me?" My nana lived down the road and she came down
34 and sat with me while I waited for the ambulance. And, the
35 ambulance came probably about 20 minutes later and took me
36 to the hospital.

37
38 Q. Can you just describe what that was like then arriving
39 at the hospital?

40 A. So, I arrived in the emergency department and I had,
41 you know, my vitals done and blood taken and all that kind
42 of thing, which was pretty distressing, and we were put in
43 a room - me and my mum. I was kind of in and out of
44 consciousness a little bit, but I remember the hospital
45 staff kind of calling just about every psych ward in
46 Victoria trying to find me a bed, but there was nothing
47 available, and I ended up just being sent to the general

1 children's ward overnight.

2

3 Q. The next morning you were seen by a mental health
4 worker?

5 A. Yeah. So, I think my mum had gone to get breakfast,
6 so I saw this worker by myself. I felt very dismissed by
7 him. He refused to give me a referral to any sort of
8 psychiatric ward. I got the impression that he thought I
9 was really just being a dramatic teenage girl and I wanted
10 attention, and I just got the feeling he didn't think I was
11 serious enough for a bed in a psych ward when I'd had a
12 suicide attempt the night before.

13

14 I'm not quite sure how much more serious you can get,
15 but I was dismissed and, yeah, there wasn't really any
16 solution offered. We ended up having to go ourselves to a
17 different doctor to get a referral to a psychiatric ward.

18

19 Q. You ended up getting a referral to a private
20 psychiatric ward?

21 A. Yes.

22

23 Q. And that was in Melbourne?

24 A. Yeah. So, it was three days before they had a bed
25 available, so I was discharged the morning after I was
26 admitted from the hospital and just kind of sent home with
27 my mum; she had to look after me for those three days.

28

29 She couldn't go to work because I couldn't be left
30 alone. She had to hide my medication and give it to me
31 whenever I needed it. I had to sleep in her room, and
32 there wasn't really - I don't think the hospital contacted
33 her at all in those three days. They might have after I
34 was admitted to the psychiatric ward, but by then I was out
35 of the house so that wasn't of much use to her.

36

37 So, on 4 June I was admitted to a psychiatric hospital
38 in Melbourne.

39

40 Q. How far away was that from your family home?

41 A. So, that was about two hours from my home, and from my
42 school, so I was quite isolated. My family couldn't come
43 and visit me until the weekend, which was my 17th birthday.

44

45 I was initially in the ICU, which was just basically a
46 big room with beds and curtains in between. I was in there
47 with adults of different ages and genders with just a

1 curtain around my bed. There was no kind of privacy, all
2 my things were locked in a cupboard and I was only able to
3 have one book out at a time, and I had to ask whenever I
4 wanted my clothes.

5
6 When I was on the phone to a friend a couple of times
7 I got told I needed to be quiet because I was disturbing
8 the other patients. And for my birthday I'd gotten a,
9 like, a heat pack that was a dog from my nana, but they
10 wouldn't heat it up for me; so, it was a pretty awful
11 experience when I was in the ICU for those few days.

12
13 Q. And, after that, you were moved to the drug and
14 alcohol ward?

15 A. Yes, for a couple of days I was on the drug and
16 alcohol ward until they could find - until there was a bed
17 free in another ward that was more suited to me.

18
19 Q. Once you ended up in that more suitable ward, was
20 there some sort of group therapy that you were able to
21 attend?

22 A. Yeah, so the hospital run a group therapy program, but
23 unfortunately it was very adult-centred and not really
24 relevant to my problems as a 17-year-old. There was a lot
25 of stuff about managing your job and stuff about your
26 relationships with your family and your children, which
27 really wasn't relevant to me as a 17-year-old at all.

28
29 There was a young person's program once a week, but
30 pretty soon after I was admitted it was put on hold so that
31 they could restructure it and I don't think it was brought
32 back until about a year later.

33
34 I felt very disengaged from the group therapies
35 because they weren't relevant to me at all. They, as I
36 said, were very adult-centred and there wasn't anything
37 about problems I was facing. I was surrounded by a lot of
38 older people, there were not many people my age in the
39 hospital at all, which really contributed to my feelings of
40 isolation and I felt very abnormal.

41
42 When I thought about what I thought being 17 was gonna
43 be like, it definitely wasn't what I was experiencing. I
44 had pretty restricted access to my phone because I wasn't
45 allowed a charger so I had to give it in to be charged
46 every couple of hours, so that really restricted my ability
47 to talk to my friends, which made me feel even more

1 abnormal. I felt very out of control and, yeah, it was
2 just very isolating.

3

4 Obviously, my friends and family were two hours away,
5 they could only come and visit me on the weekends because
6 of work and school, so I was really alone.

7

8 Q. Can I ask you about medications that you were given
9 during that stay?

10 A. Yeah. So, I kind of cycled through quite a few
11 different medications and none of them seemed to work for
12 me. A lot of them had pretty awful side-effects. There
13 was one that made me vomit for about a week straight, I
14 couldn't really keep any food down. So, they were all
15 pretty awful, I didn't have a great experience with them.

16

17 Q. And then, in around August 2015, you began receiving
18 TMS treatment?

19 A. Yeah, so that involved - it's non-invasive. As I
20 understand it, it involves the use of a magnet to stimulate
21 neurotransmitters in your brain. We had to get permission,
22 I think, from the hospital board because it hadn't been
23 fully researched on under 18-year-olds yet. But I did end
24 up having it and it made a huge difference to me, it
25 allowed me to stabilise enough that I was able to be
26 discharged and go home.

27

28 Q. So you had a stay at this private psychiatric hospital
29 that you've described of a period of three months?

30 A. Yeah, about two and a half months.

31

32 Q. And then you were discharged, but still required to go
33 back every couple of months to receive this TMS treatment?

34 A. Yeah. So, I went back, probably the first time after
35 that was a few weeks later, and kind of in between those
36 two admissions I had one Skype appointment with the
37 hospital psychiatrist, but that was it.

38

39 And then, after that, I had to go back every couple
40 of months to receive TMS. I would do it in the school
41 holidays because at the start of 2016 I went back to
42 school, completed my Year 12 over two years. So, I'd go
43 into hospital to have TMS every holidays, but I never
44 really had any contact with the hospital in between my
45 admissions. There was no communication.

46

47 When I was discharged every time I was given the exact

1 same discharge summary self care plan that was very
2 general. No-one ever really went through it with me, and
3 it wasn't helpful to me because it had stuff about, I
4 think, like, exercising, going for a run, and I hate
5 running, so it was really quite general and not helpful to
6 me.

7
8 And, every time I was discharged it would kind of be
9 like, hand in your TV remote and go. I took public
10 transport to get home a lot of the time, but I don't
11 think - a lot of the time they didn't really ask how I was
12 getting home, so that was difficult.

13
14 Q. Can I take you to 2018, and you moved to Melbourne to
15 study?

16 A. Yeah. So, I moved to Melbourne to start Uni and the
17 hospital began to offer outpatient TMS which meant I didn't
18 have to be admitted as an inpatient for a 45 minute session
19 every day which worked around my life a lot better because
20 I couldn't work while I was in hospital.

21
22 So, I'd organised that but when I was on the way to
23 the appointment I was getting all these phone calls saying
24 that, "Oh, have you got your referral?" And I asked, "What
25 referral?" Because the referral had always been done
26 internally when I had it as an inpatient. They said I
27 should have gotten a referral for the TMS but I could just
28 go to the GP tomorrow and get one and I'd still be able to
29 have TMS that day.

30
31 Unfortunately, the calls in the next half an hour kind
32 of kept coming and the goalposts kept being moved. Then it
33 was, you need one from a psychiatrist, you need one from a
34 psychiatrist before you can have it today; your
35 psychiatrist in the hospital won't give you one; you're
36 just gonna have to wait until you can get the referral.

37
38 So, when I was told I couldn't have it I was actually
39 in an Uber on the way to the hospital. I think we passed
40 it when they told me that I couldn't have it, so I kind of
41 just had to go home and wait until the next week to have
42 it, which was very inconvenient as I'd moved the due dates
43 of all my Uni assignments to the next week when I thought
44 that I'd have had TMS and it would be a lot easier to deal
45 with, and now, they were all due when I was supposed to be
46 having TMS.

1 I'd kind of re-organised my life, taken time - moved
2 my work hours around and, yeah, felt like the goalposts
3 just kind of kept being moved.
4

5 Q. Can I ask you about some specific problems that you've
6 encountered with the mental health system. Starting with
7 the idea that, when you asked for help, it wasn't there?

8 A. Yeah, so I think there's a lot of public attention,
9 media attention on the fact that - and I know I used to
10 think this - that you should just ask for help and
11 everything will be better and people have acute mental
12 illness because they just haven't asked for help and, once
13 you do that, it will be all sunshine and rainbows and be
14 great. But unfortunately that wasn't my experience.
15

16 When I took that really, really difficult step, that
17 really heartbreaking step of trying to ask for help, there
18 was really nothing there for me. I was kind of greeted
19 with silence in return. So, that's just really distressing
20 when you take that very difficult step of asking for help,
21 and there is just nothing there; it makes you feel very
22 hopeless and like you're really never gonna get better.
23

24 Q. In terms of your interaction with Headspace, it was
25 insufficient to meet your needs?

26 A. Yeah. So, I think Headspace has a good role, I think
27 it does help a lot of young people with maybe every day
28 stressors or mild, more mild mental illness than what I
29 experienced, but for me it just wasn't enough; I needed
30 more intensive care but I found there was nothing for me
31 between the GP, Headspace and the emergency room.
32

33 There was a real gap, especially youth-specific
34 services. I think even just after Headspace there's
35 nothing tailored to young people and their needs, so that
36 was a real problem I faced.
37

38 I think Headspace has a good role but it just wasn't
39 enough for me, but there was nothing else.
40

41 Q. What about how you were treated by health
42 professionals in terms of whether you're taken seriously or
43 whether you were dismissed?

44 A. Yeah, so as I've touched on, I did feel very dismissed
45 by a lot of health professionals. I think a lot of them
46 didn't take me seriously or, kind of, downplayed what I was
47 going through, invalidated my feelings. That's not to say

1 I haven't had good experiences, but unfortunately I've had
2 a lot of bad ones, and you shouldn't really be having any
3 bad ones.
4

5 Q. In terms of recommendations for change, you've touched
6 on this already in terms of the gap between GP or Headspace
7 and then emergency care. What do you want to say about
8 that?

9 A. Yeah, so I think that there needs to be, obviously,
10 something in between there. My mum's a diabetic and they
11 wouldn't make her wait until her foot had gangrene before
12 they did something about it, whereas unfortunately with
13 mental illness, I think that what happens is that, if you
14 can get help, it just maybe stabilises you enough that you
15 are not in immediate danger to yourself and then you're
16 kind of just left on your own.
17

18 I feel like I've really had to fight very hard to get
19 the help I've just needed to survive. I don't think I
20 really know what it feels like to be thriving and be happy.
21 I think that the help I have gotten has just been enough to
22 get me stable and enable me to stay alive, but not really
23 more than that.
24

25 So, I think there is a real gap in those services
26 between primary care and the emergency room. And, the
27 primary care that you can access usually just stabilises
28 you.
29

30 Especially I think the Medicare ten sessions is really
31 just not enough; that's less than one a month if you want
32 to stretch it out over the whole year, and so, it's really
33 not enough to enable you to be functional and be happy and
34 live your best life, I guess. It's not even enough to
35 enable people to survive sometimes, so I think there needs
36 to be something to address that gap in between primary care
37 and the emergency room and primary care also probably needs
38 to be more accessible and there needs to be more of it.
39

40 Q. Just in terms of, you've talked about your experience
41 of being in a regional area and how difficult access was
42 being outside of a city.

43 A. Yeah, so obviously, as I touched on, the services that
44 I could access were very far away, I was reliant on my mum
45 to take me there, take me back. I had to take time off
46 school because the opening hours were such that I couldn't
47 go to appointments outside of school hours. Because, even

1 if I had one after school, I would have to leave school
2 early to make that appointment anyway.

3
4 So I think, if I hadn't had the family support that I
5 did, I wouldn't have been able to access anything except
6 the local GP. I'm really lucky that I had a supportive
7 family, but not everyone does, and those people are kind of
8 left by themselves because they can't access the few
9 services that there are, like, practically.

10
11 Q. Just picking up on that point, you're talking about
12 needs for support for families as well?

13 A. Yeah. So, I think the whole experience for my family
14 was obviously very distressing, but there wasn't really any
15 support offered for them. I think one of my sisters sought
16 their own help, but they kind of had to do that themselves;
17 that wasn't brought up by anyone around me.

18
19 And my sisters were 13 and 15, so it was a lot for
20 them to deal with as, you know, young teenagers/children
21 really, so there really wasn't anything. There wasn't
22 anything for my mum, there wasn't anything for my dad,
23 there wasn't anything for my nana, it was just - they were
24 just kind of left to deal with it themselves and to manage
25 me themselves was so difficult let alone manage their own
26 feelings, I guess.

27
28 Q. One of the others things that you've raised in the
29 course of your evidence is about the need for there to be
30 better contact and follow-up after a hospital stay?

31 A. Yeah. So, in between my hospital admissions there
32 was - I think I had one Skype appointment with my
33 psychiatrist. There wasn't really any communication in
34 between the sessions. If I had TMS booked in, the staff
35 would kind of call me to organise that when it was coming
36 up, but that was it and that was kind of something they had
37 to do anyway, there wasn't really any communication in
38 between then.

39
40 Really, I could have died in between admissions and
41 no-one would have known because there was just no contact
42 and, on discharge, it was kind of like I was just cut loose
43 and left to go by myself, which was really hard for me; you
44 know, I had to organise all my post discharge stuff and,
45 yeah, it was just quite abrupt when I was discharged, it
46 was just like a sudden cut off.

1 Q. Just finally, in the course of your evidence you've
2 talked about, that services need to be adjusted to better
3 meet the needs of young people?

4 A. Yeah, so I think, especially as a young person, the
5 care I could access wasn't suited to me: the group therapy
6 in the hospitals was adult-centred, I was surrounded by a
7 lot of adults which made it really difficult for me, it
8 really kind of reinforced those feelings that I was very
9 abnormal, and I was very lonely, and I was a freak.

10
11 That was how I was feeling at that time and I feel
12 like maybe, if I had been around other people close to my
13 age, I wouldn't have felt that so acutely, because it would
14 have shown me that this was okay and that there wasn't
15 anything wrong with me. Well, I was sick, but it wasn't a
16 personal fault and it wasn't anything I'd done and it
17 wasn't something that made me different.

18
19 And I think, yeah, the other thing was the support I
20 could access through the GP, I guess, especially being a
21 rural area, wasn't youth-centred or youth-focused. It was,
22 you know, the only recommendation was the anxiety course
23 which was for over 18-year-olds, and there wasn't kind of
24 any support about what I should be doing about school.

25
26 Luckily, my school was very, very supportive, I'm glad
27 I had those supports in place, and I was very lucky to have
28 that, but I also don't think that's a role my school should
29 have had to take on.

30
31 Yeah, there was no support from mental health services
32 and how to access that or how to manage my friendships or
33 anything like that that would have helped me in that stage
34 of my life. And things like opening hours of Headspace as
35 well; like, if they'd had an evening session once a week,
36 that would have made such a huge difference to me.

37
38 So, yeah, I think definitely services could change to
39 better meet the needs of young people

40
41 MS COGHLAN: Thank you, Amelia. Chair, are there any
42 questions from the Commissioners.

43
44 CHAIR: No, thank you very much, Amelia, for taking the
45 time to share your reflections with us, thank you.

46
47 MS COGHLAN: Thank you. May Amelia be excused?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

CHAIR: Yes.

<THE WITNESS WITHDREW

MS COGHLAN: The next witness is Dr Gaynor Blankley, and I call her now.

<GAYNOR BLANKLEY, affirmed and examined: [10.33am]

MS COGHLAN: Q. Thank you, doctor. You've provided a statement with the assistance of the Royal Commission?

A. Yes, I have.

Q. I tender that statement. [WIT.0002.0005.0001] You are the Deputy Clinical Services Director, Mercy Mental Health, and head of Perinatal Mental Health?

A. Yes, I am.

Q. And you hold qualifications of a Bachelor of Medicine and Bachelor of Surgery?

A. I do, yes.

Q. And also a Master of Psychological Medicine?

A. I do, yes.

Q. Just in terms of your current role as Deputy Clinical Services Director, Mercy Mental Health and head of Perinatal Mental Health, can you just briefly outline the key aspects of that role?

A. Okay. So, that role is four days a week and half of that time is clinical service delivery, so I'm a clinician in clinics in that role. And then the role also involves, I guess, coordinating, heading up and running the service in conjunction with a manager, and the service also involves some teaching; that's teaching of doctors who are studying to be psychiatrists in Perinatal Mental Health or general psychiatry; maternity care doctors, so obstetricians and gynaecology trainees, midwives in the hospital; and also medical students; and also to GPs, maternal and child health nurses in the community. And the role also involves some research, but that's a small component of it.

Q. Okay. I'm just going to ask you in a moment what is meant by "perinatal mental health", but firstly, can I just ask you, why is it important? Why do you view it as an

1 important thing?

2 A. Look, 50 per cent of the population are women, and
3 there's a significant number of years in a woman's life
4 when she is either planning - for a lot of women, most
5 women - thinking, planning or being pregnant or raising
6 very young children, and so, I actually think that
7 perinatal mental health, at one level we need to have some
8 subspecialty knowledge, but at another level it should just
9 be a part of mental health services mainstream and it be
10 sort of woven into the, I think, the fabric of all mental
11 health care services.
12

13 Q. Can I ask you now what is meant by perinatal mental
14 health?

15 A. So, specifically perinatal mental health does refer to
16 the time in a woman's life when she's either planning a
17 pregnancy, or is pregnant, or in the postnatal period.
18 Generally speaking with respect to services, it's up to
19 12 months postnatally but, I mean, it can be considered
20 longer as well.
21

22 The key aspects of perinatal mental health are
23 actually the mother's mental health, but also her
24 relationship with her infant who at that stage of their
25 lives is wholly dependent usually on the mother as a
26 primary caregiver but not necessarily. But at that stage
27 of either the unborn infant's life or the newborn infant's
28 life their development is very much experience expectant
29 and dependent. That means that, as they're developing,
30 they need experiences, they need the environment, and also
31 the environment, either the pregnancy-related environment,
32 so the health of their body and wellbeing while they're
33 carrying - while they're pregnant, or else the environment
34 that they're able to provide postnatally also impacts on
35 the infant's growth, development and wellbeing.
36

37 Q. There's two things there: you're talking about not
38 only the mental health of the mother?

39 A. Yes, that's right.
40

41 Q. You're also talking about the impact on the child?

42 A. That's right, yeah.
43

44 Q. I'll ask you more about that a bit later. Can I just
45 ask you this at the moment: the perinatal period is
46 considered to be a high risk period of illness?

47 A. Yeah.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. For either onset, relapse or exacerbation?

A. Yeah.

Q. Can you just expand on that, please?

A. So, at some levels the rate of having a mental health disorder in the perinatal period is no different to other times in one's life, except that there are a few factors that can change the course of the illness during that time.

Some of those factors are that during that time in your life, in one's life, there are - you're much more likely to have physical illnesses or physical conditions that are pregnancy-related or postnatally-related. There are also a whole range of changes in the way that you see yourself, identity changes.

So, for example, at this point in time I see myself as a doctor and also there are other aspects of my life, but it's coming to terms with, how do I manage all these things in my life, how am I going to be a mum?

So there are identity changes, there are social changes: some of those are financially-related, some of those are relationships with either the father of the baby or your partner, they're frequently different people.

There are also changes at times to - I mean, generally changes to income and financial stressors, and often there are also changes in relationships with family as well and in-laws or out-laws as well. And these are all stressful and these are known to be stressors with respect to the onset of anxiety, depression or a mental health disorder of any kind.

Q. Okay. So, can I just ask you now, in terms of the types of treatments or interventions that are provided as part of perinatal mental health care, just in terms of principles rather than going into the specific treatments, just briefly?

A. Okay. So, I mean, the principles of treatment should always begin, I think, with prevention and prevention goes right back to thinking about what are the factors that we can do in the community at large to prevent, and then early identification of illness, so that you can prevent the length or duration - getting into early treatment and prevent the sequelae of illness.

1
2 So, prevention, and then there's early intervention,
3 so early onset of treatments, and the treatments in
4 perinatal mental health are in some respects the same as
5 the treatments for all mental health disorders, but you
6 actually have to consider the impact of treatment on
7 pregnancy and the infant, on the unborn infant, and also
8 the impact of treatments when you're - if you're
9 breastfeeding.

10
11 So, you do need to understand the physiology, that's
12 the changes in a woman's body when she's pregnant; with
13 respect to choice of treatment, you need to understand the
14 risks and impact of treatments on the unborn infant in
15 particular.

16
17 Q. Okay, we'll come back to that just in a moment. Can I
18 ask you about education awareness, screening and
19 prevention?

20 A. Yes, I mean, that's a topic that I actually think is
21 really, really important and it probably is something that
22 shows the whole fragmentation of, not just - of our whole
23 mental health care system going right back to primary care.
24

25 I think, thinking about women and - sorry, what was
26 your question, it was about?

27
28 Q. So, in relation to the topic of education?

29 A. Oh, education, that's right.

30
31 Q. Awareness, screening and prevention.

32 A. So, going back to education: I mean, I think there are
33 choices of medications - if we focus on medication, there
34 are actually choices of medications that could be
35 prescribed or not prescribed to women at the onset - at the
36 outset, that is, before they're even thinking of having a
37 baby.

38
39 So, education to primary care around prescribing
40 practices for women is absolutely fundamental and
41 essential. Education to decrease stigma, because stigma is
42 a huge issue that has been found for women in the perinatal
43 period.

44
45 Q. Can you just expand on that?

46 A. I think that, actually you can look at organisations,
47 peer organisations, like in Victoria it's PANDA, the

1 Perinatal Anxiety & Depression Network. And pregnancy and
2 childbirth, it's meant to be a period of great joy and hope
3 and there's particular stigma for women around feeling -
4 becoming anxious and depressed during that period of time.
5

6 So a particular feeling: you know, I'm meant to be
7 happy, and also, if you - women can feel very ashamed as
8 well that they're not enjoying or they're not able to meet
9 the needs of their young baby, so there's a lot of stigma.
10 And, I think education can really help raise community
11 awareness as well as the awareness in primary care and also
12 actually in mental health care services.
13

14 So education in mental health care services is an
15 enormous need, because actually, once women - if a woman -
16 one of the big issues is a lack of understanding of what
17 it's actually like to have a mental health disorder when
18 you're trying to care for a baby.
19

20 So for example, if I had a mental health care disorder
21 and I went to seek care I might be given two weeks off
22 work, and I could go home and have some support perhaps,
23 but not have to work, not have to think, not have to
24 concentrate. You can't do that with a baby, you can't put
25 a baby aside for two weeks while you're waiting for your
26 treatment to benefit for you and to kick in.
27

28 Also in perinatal health care the threshold for what
29 is considered a crisis is much lower than in the community
30 at large, so there needs to be education within the system
31 around those sorts of issues as well.
32

33 Q. Can you just flesh that out please, in terms of what
34 you're talking about in that crisis, the context of that
35 kind of crisis?

36 A. Yeah, so I think - I don't actually have data on this,
37 a lot of this will come from experience within the service.
38 But the majority of mental health disorders in the
39 perinatal period are what are called the high prevalence,
40 low acuity disorders: anxiety and depression. I mean, I
41 don't particularly like those turns of phrases but that's
42 what they're called.
43

44 So, they're managed in the primary care setting, so
45 women attend their GPs and then maybe referred to a
46 psychologist or a psychiatrist in the community in which
47 they're living. But they do also have to care for a baby,

1 and if they find that they're unable to care for a baby,
2 they can feel really - that can be - they can feel a lot of
3 shame or they can feel a lot of guilt and that can actually
4 make their illness worse.

5
6 So, frequently they would then benefit from having
7 some time in an inpatient setting, but it can be very
8 difficult to sort of navigate - get a woman admitted
9 through the access into a mental health care system for
10 inpatient care because it can be considered at that point
11 in time when a clinician in primary care rings and tries to
12 access the service, that their illness isn't acute enough,
13 they're not unwell enough.

14
15 And the fact that they're not able to attend to their
16 infant's needs, or finding that extremely difficult, isn't
17 considered to be as big a risk factor as it should be.

18
19 Q. Can I ask you then about the idea of screening and
20 what that involves?

21 A. So screening: screening is sort of like throwing out a
22 net into the - like, you go out and ask everybody who is -
23 whether: screening is a process by which you ask everybody
24 particular questions or give them a particular
25 questionnaire to sort of see whether or not they reach a
26 threshold point in response to those questions.

27
28 Q. And so, who administers that screening?

29 A. Okay, sorry, yeah. So, screening can be done
30 antenatally in antenatal clinics or by obstetricians, by
31 midwives and by GPs, and then postnatally screening can
32 also be done by GPs and by - at postnatal checks and cares,
33 at the postnatal check.

34
35 And screening can be done by - there's a couple of
36 tools that are very well ratified worldwide that can be
37 used for screening, and what they do is, they provide a
38 sort of an indication that this person should have further
39 clinical evaluation. They're not diagnostic, they just
40 pick up that this person looks like they are at risk of
41 having an illness.

42
43 Q. And so, I'll ask you about this later, but then in
44 terms of the treatment pathway that might follow, is that
45 working effectively at the moment?

46 A. I think it's really, really sporadic, I really do. I
47 think in some areas it might work quite well and then in

1 other areas - you know, it really depends on whether there
2 are services as to whether that works well.

3

4 Q. I'll ask you more about that later. So, in summary,
5 there is this screening process to identify potential risk?

6 A. Yep, yep.

7

8 Q. But the process for then managing that risk is
9 sporadic?

10 A. That's right, very sporadic, yep.

11

12 Q. I want to ask you something very specific about
13 treatments.

14 A. Yep.

15

16 Q. There are a number of treatments that might be
17 available depending on a person's needs?

18 A. Yes, that's right.

19

20 Q. If I could just ask you about medication, and really,
21 the challenges that might be posed with the use of
22 medication: you've talked about during pregnancy, during
23 breastfeeding. Can you just expand on that, please?

24 A. Okay. So, when a woman is pregnant and she's being
25 prescribed medication, you really need to think about
26 medication in terms of - or even before she's planning a
27 pregnancy - will this medication impact on her fertility at
28 all? Is it likely to increase risk of pregnancy loss? Is
29 it likely to cause an increase in malformations to her
30 infant? Is it likely to cause any risks across pregnancy
31 in terms of foetal growth and development across pregnancy,
32 or length of pregnancy? And then is it likely to cause any
33 impact for the infant when it's a newborn? And is it
34 likely to cause any impact for the infant in terms of
35 longer term development? And how much of that medication
36 is likely to be expressed in the breast milk? What
37 percentage of it will be in the breast milk? And so,
38 therefore, you know, can it be used in breastfeeding?

39

40 So these risks or these issues need to be considered.

41

42 The other issue that needs to be considered with
43 respect to medication is the fact that across pregnancy a
44 woman's blood system is sort of one and a half times the
45 volume that it is normally - like pre-pregnancy or
46 postnatally, so there's a dilution effect of medications,
47 and also - and some of these factors are not actually known

1 well enough at all, but we just know that these are issues
2 with respect to how we manage medication in pregnancy and
3 postnatally

4 Q. Can I move on to ask you about the setting of
5 treatment?

6 A. Yep.

7

8 Q. Again just briefly, if you explain the tiers, just in
9 brief terms?

10 A. Okay, so Australia' got a primary tier - a primary,
11 secondary, tertiary healthcare network. Primary care is
12 like general practitioners, psychologists, maternal and
13 child health nurses. Secondary will be private
14 psychiatrists, psychologists as well and an outpatient
15 service, and then tertiary will be inpatient services.

16

17 Q. I'll come to ask you later about the interaction
18 between those three tiers but, before we get to that, can
19 you just indicate when perinatal mental health treatment
20 might be indicated?

21 A. So really, it's indicated for any woman, I think, from
22 potentially planning a pregnancy through to when her infant
23 is born and crossed the first year of life, and so, it's
24 indicated in women who have a pre-existing mental health
25 illness that they're living with who are wanting
26 pre-conception planning and how to manage their illness
27 across that period of time.

28

29 It's indicated in women who develop an illness in
30 pregnancy for the first time and they may go on and have an
31 illness further on across - that may be the start of an
32 illness that is ongoing. And, there are some specific
33 pregnancy-related illnesses that it's indicated in as well
34 that develop late in pregnancy and early in the postnatal
35 period.

36

37 Q. Are you talking about mental illnesses or physical
38 illnesses?

39 A. Mental illnesses, yeah, sorry.

40

41 Q. Which groups in the Victorian community are the most
42 at risk?

43 A. So, the groups in Victoria that are most at risk will
44 be women who have a pre-existing major mental illness, so
45 women living with schizophrenia or a bipolar illness, also
46 women with personality disorders, particularly severe
47 personality disorders. Women from - Aboriginal and Torres

1 Strait Islander women are at greater risk of accessing
2 services. Women who are - sorry, I've lost my train of
3 thought.

4
5 Q. Some other examples might be women who don't have a
6 home?

7 A. That's right, yes. Women without a home and I think I
8 listed a few: women who are --

9
10 Q. From culturally and linguistically diverse
11 backgrounds?

12 A. Culturally diverse backgrounds, yeah.

13
14 Q. Also LGBTI?

15 A. That's right, LGBTI women as well.

16
17 Q. As well as women living in situations of family
18 violence?

19 A. That's correct, yes.

20
21 Q. Who have experienced childhood trauma?

22 A. Yes, that's right.

23
24 Q. And also those who may have also experienced sexual
25 assault previously?

26 A. These groups of women, yes, these are the groups of
27 women who are at higher risk.

28
29 Q. And then finally, also women living with alcohol and
30 illicit substance abuse disorders?

31 A. Yes, that's right.

32
33 Q. Substance use disorders, I should say. Why are they
34 then particularly more at risk?

35 A. As a group, and for different reasons within that
36 group of within, within those different groups of women,
37 they frequently have had really difficult experiences in
38 the past accessing either authoritative services - and they
39 can see the health care service as authoritative.

40
41 They also have had a lot of shame and stigma, and
42 there's a lot of fear within these different groups of
43 women about being judged about - in some of these groups of
44 women there's a lot of fear that, if they present and ask
45 for help, that they will have their babies removed, and so,
46 a lot of these groups of women - so Aboriginal and Torres
47 Strait Islander women have that fear, so do women who are

1 homeless, so do women who have grown up with a lot of
2 services, like, under the child protection system
3 themselves, so have come from violent backgrounds. So,
4 these groups of women are fearful of accessing services,
5 that it will mean that their children will be removed from
6 their care.

7
8 There's a lot of shame, and the services as well are
9 often just not organised practically - logistically to sort
10 of meet their needs as well. Sometimes the timing of
11 appointments are very specific and, if you don't turn up,
12 then you've missed your appointment, and so, that can be
13 very difficult.

14
15 Certainly, those groups of women find it very
16 difficult to access primary care because of those
17 logistical reasons, and cost, and secondary care as well,
18 because of cost.

19
20 Q. Can I ask you about the importance of mental health
21 care in the perinatal period, about that topic, and I'll
22 ask you some specific questions?

23 A. Okay, yeah.

24
25 Q. In your statement you say:

26
27 "The importance varies across the various
28 phases of the perinatal period."

29
30 So, for example, if you consider pre-conception care,
31 prenatal care and then postnatal care, can you just briefly
32 address those three areas?

33 A. Okay. Preconception care is an opportunity to plan
34 with a woman living with a mental health disorder how she
35 might best manage her pregnancy with respect to her mental
36 health. So, that can be planning for medication
37 treatments, which is like planning to be on the - what we
38 say as being the minimum effective treatment of the least
39 risky medication in pregnancy.

40
41 Q. Yes.

42 A. So, you can plan that ahead of time. Just like when
43 women are planning a pregnancy and they go to see the
44 doctor regarding, you know, have I had all my
45 immunisations, or should I take Elevit, which is to make
46 sure your physically well in pregnancy, you can do that
47 prenatally.

1
2 Also, you can actually discuss with a woman what's
3 going on in her life and how she might best have supports
4 in place, what are just community supports, so that's with
5 prenatal care.

6
7 In the early stages of pregnancy - and also it's
8 really important, if possible, to do that planning because
9 you can make some specific medication changes if
10 medications are ones that maybe are more risky and you can
11 really think about making some changes there.

12
13 Across pregnancy, early treatment is really important.
14 I mean, a high percentage of women do suffer from
15 anxiety/depressive illnesses in pregnancy. So it's really
16 important to get services in place at that point in time,
17 and to begin early treatment, and it can assist with
18 preventing secondary problems associated with suffering
19 from a mental health disorder in that time of life, and
20 also plan for services.

21
22 And postnatally early intervention is essential
23 because of the impact that untreated mental health
24 disorders can particularly have both on the mother and on
25 the mother-infant relationship. And then also on her
26 relationship with partner and her family and the wider
27 community.

28
29 Q. Can I just pick up on that, the impact that you've
30 just raised and ask you about specifically the impact on
31 the infant.

32 A. Uh-huh.

33
34 Q. And then secondly, the impact of the infant. If you
35 consider it that way: so the impact of maternal mental
36 health on the infant, if you could just address that,
37 please?

38 A. Okay. So, we're born very immature as human beings,
39 and in particular our brains are very, very experience
40 expectant and independent, I've used that turn of phrase
41 before.

42
43 Q. Sorry, can you just break that down, what are the
44 words you're using?

45 A. I use the words experience expectant and dependent.
46 So, the actual growth development, and I guess I'd say
47 wiring of our brain - I'd use, say, a wiring metaphor for

1 that - depends on the experiences that we have, and our
2 brain's wiring pathways actually literally sprout out and
3 grow and are looking for connections.
4

5 Perhaps it's easier to use the visual cortex, visual
6 part of our brain. When infants are born, they cannot
7 really process what's coming in through their eyes, but
8 over the first year of their life or ten months or so of
9 their life, they actually make sense of material that's
10 coming in, like, through their eyes and it goes to their
11 brain, and their brain develops in response to the
12 information that they are taking in.
13

14 That's the same with a whole range of growth
15 development and experiences for an infant. So, treatment
16 of the mother's mental health is really, really important
17 across the early period of an infant's life, really
18 important, because she can't - if she's really quite
19 depressed and she can't - and it's very hard to sort of
20 interact and play with her infant, it is actually - the
21 infant learns that the world isn't such a happy, joyful
22 place so to speak and it actually has been shown to impact
23 on language development and behavioural development down
24 the track for those infants if depression isn't treated and
25 intervened with early.
26

27 Q. And so, what about then - you previously touched on
28 this - but the impact of the infant on the mother?

29 A. So, the infant can - I mean, just in terms of some
30 medications used there can be an impact there, but also,
31 infants do wake up a lot at night and so interrupt sleep
32 and that can actually impact on the capacity to recover.
33 You can't just put an infant aside for a week or two while
34 you recover, unless somebody can come in and assist you, so
35 you can't, say, rest and recuperate so easily.
36

37 Also, you can experience - women describe experiencing
38 an enormous amount of guilt about not being able to give
39 their infants what they'd like to give them and really want
40 to give them, and then that kind of interacts back and is a
41 stress in its own right, that feeds back into becoming more
42 anxious or more depressed and impacting on a sense of self,
43 and so complicates actually the personal recovery process,
44 if that make - yeah, the personal recovery process as well.
45

46 Q. Can I move on to ask you briefly about data or
47 research?

1 A. Yes.

2

3 Q. What do you say about there being data available that
4 provides evidence for the effectiveness of perinatal mental
5 health care?

6 A. So, that's a really difficult area to discuss, and I
7 think in some ways science let's us down. Because, if the
8 focus is too much on data, and if the focus is too much on
9 quantitative data, one of the problems is that then you can
10 end up - we've ended up with, you know, hundreds of studies
11 that sort of can amalgamate sometimes to, if you look at
12 them individually to say, well, this one shows this small
13 effect and this one shows that small effect and then you
14 put them all together and you can say, well, there's not
15 enough evidence.

16

17 So, it's really important with the data to try to make
18 sense of it in terms of trends and to also look at it from
19 a qualitative point of view as well as a quantitative point
20 of view. So quality is experiences of and think about the
21 data, not just actually look at the hard numbers.

22

23 We do have quite a bit of data around medications and
24 individual medications and their impact on which
25 medications to use or not to use, but it's really difficult
26 to actually say which - there's not a specific treatment
27 that should occur in this way for all the different aspects
28 of perinatal mental health care.

29

30 What we do know, though, is that you really need to
31 focus on understanding the woman, her relationship with her
32 infant, what it's like for her in the context of her life
33 that she's living in and put that all together, understand
34 her sort of situation. And there's data globally to kind
35 of - for that and the importance of treatment in terms of
36 her ongoing wellbeing and the infant.

37

38 Q. So that person-centred approach?

39 A. Yes.

40

41 Q. I asked you earlier about the tiers of mental health
42 care in Victoria, and you described those. I just want to
43 ask you now about, how are they operating in Victoria at
44 the moment to meet the needs of pregnant women?

45 A. I think that the services are really - at one level
46 there's quite a few services in Victoria, but at another
47 level they're - I think they're not funded well enough

1 overall and they're quite sort of, they're quite sort of
2 fragmented.

3
4 So the pathway for a woman from being unwell in the
5 community to accessing primary care with her GP, a
6 psychologist, and I think we've heard from other people
7 that the number of psychology sessions available are
8 absolutely inadequate: I mean, tens sessions is less than
9 one a month, and then GPs are really busy.

10
11 To then secondary health care: the freeze on
12 psychiatry sessions through Medicare has meant that there's
13 quite a gap in Medicare rebates for women, so cost is
14 actually an issue in terms of accessing care; through to
15 accessing inpatient services if they are required. It's
16 very fragmented, and it depends a little bit on where you
17 live and it shouldn't be like that and I think --

18
19 Q. Sorry, go on, I don't want to cut you off. Go on.

20 A. I actually think that the notion of just having
21 separate perinatal mental health services is actually not a
22 helpful one or a useful one. It goes back to what I said
23 at the start, where 50 per cent of the population are
24 women, women become pregnant, women have infants, and I
25 actually think that there should be clinician and
26 stakeholder-led funding from above and that perinatal
27 mental health services should be embedded in all area
28 mental health services and funded, not sort of, okay, now
29 you have to do that and add that in to what you're doing
30 out of current funding, but they should be specifically
31 focused on and funded so that the access to care through to
32 all areas is available.

33
34 Q. What do you say then about the interaction between the
35 services that currently exist? And I mean that in terms of
36 the various tiers.

37 A. I think it can be very difficult to sort of access
38 services from primary health care through to inpatient care
39 or area mental health services if required, and so, it can
40 be very difficult if you require admission to get into
41 hospital, and it can be very difficult to access - yeah, so
42 it's very difficult if you get into hospital and I think
43 also if you've been in hospital, often there's not a step
44 down - there's nowhere to step down to, so you go straight
45 from hospital back to an occasional visit to your GP, which
46 is just - there's huge gaps in the service delivery.

47

1 Q. And so, just in terms of best practice from your point
2 of view, what does that look like?

3 A. I think best practice should be led by clinicians,
4 stakeholders; I mean, there needs to be an understanding of
5 costs, serve, care, but it definitely should be led by
6 clinicians and peers, and that --

7
8 Q. Do you mean by that that there's a hierarchy?

9 A. Yes, I do, I mean a hierarchy and that actually --

10
11 Q. And how would that hierarchy work?

12 A. So, I think that the hierarchy, like, there needs to
13 be: these are the practices that we think should be
14 implemented clinically, both in terms of actual clinical
15 guidelines, and also these are the pathways that need to be
16 followed and these are the access points.

17
18 Pathways and services should be mapped out and they
19 can be mapped out; I mean, it's a bit of a task, but really
20 literally mapping out from pre-primary care, so when
21 someone's just living in the environment and perhaps
22 feeling stressed, to primary care, to then secondary care,
23 to tertiary care. And actually looking at access points,
24 where the blockages are and sort of gap filling there.

25
26 And I think this should be implemented from above so
27 that it's expected, so that it's the standard of care and
28 that it's not idiosyncratic and individualistic, so that
29 this person does this and this person does that and that
30 person does this.

31
32 I also think it should be funded, this funding
33 shouldn't be sporadic, it should be actually an integrated
34 model of care. I think actually it's really important not
35 to just look - even as I'm speaking, like, as I'm here as a
36 witness on perinatal mental health, I don't think perinatal
37 mental health should be isolated as just a subspecialty.
38 There needs to be a bit of a subspecialty component and
39 understanding, you need to have leaders and people who
40 understand it, but it actually needs to be woven into the
41 substrate of the system.

42
43 And I also think there needs to be an educational
44 component that goes from community through to primary care,
45 secondary care, and also a research component as well to
46 really understand what it is that we need to deliver

47

1 MS COGHLAN: Thank you, doctor. Chair, are there any
2 questions from the Commissioners?

3
4 CHAIR: Q. I'd like to ask one, thank you very much. In
5 relation to the feedback that you receive from the women
6 that you're working with about the complexity of navigating
7 that system, what do they say to you?

8 A. I think, I mean, they do find it really difficult and
9 complex. Cost is a huge issue. A lot of feedback that
10 we'd get would be around cost: that it's too expensive to
11 have care in the primary care setting in the private
12 setting, and so, you know, they budget out their
13 appointments.

14
15 And also, accessing services at times of crises as
16 well, and that the crisis point is lower. When I say
17 "lower", it's different. I don't mean it's lower, it is a
18 crisis point, but it's different and not always recognised
19 or frequently not recognised.

20
21 Q. I think that's an important point you made in the
22 statement a few times, that you felt people underestimated
23 the risks that there were for the mother and the infant at
24 this point of time?

25 A. Absolutely.

26
27 Q. And hence the importance of them getting access to
28 treatment. Can you just make sure we understand that
29 clearly, what you're saying there?

30 A. So, I mean, there's obvious crises of - first of all,
31 the worst and the most tragic is loss of mother and loss of
32 an infant; that's the most tragic and is rare but it
33 occurs. There's a myth that, if a mother has a baby then
34 she's at less risk of, say, taking her life and that's not
35 true. So, that's one thing. I think - I lost track of
36 your question.

37
38 Q. I think you were saying people underestimate the
39 urgency of access to care.

40 A. Yes, that's right. The next thing is that people
41 underestimate that the long-term need, if you are looking
42 after an infant, that it's not just the mum, there is an
43 infant there and that infant is really dependent on her,
44 largely speaking. But then there's also a family network,
45 and you can't just - there are not necessarily people who
46 can just jump in and support a person - a mother at home
47 with an infant.

1
2 I think when an individual adult is anxious, depressed
3 or has an illness, you can sometimes manage individual
4 adults in the community for longer, because you can sort of
5 touch base with them, you can make sure that they're
6 looking after themselves; you can actually do that and
7 check in with them. But I think when there's an infant
8 it's actually - she can't just go away and put the infant
9 in the spare room for three hours while she has a bit of a
10 break - or he. I mean, it's mainly women that we're
11 talking about.
12

13 So, I think that that's often not recognised, that
14 that's actually a really, really important point, both for
15 the mother's wellbeing and her recovery, but also for the
16 infant's development and wellbeing.
17

18 Q. Can I just ask how well placed you think the maternal
19 and child health nurse network is to respond to mental
20 health issues?

21 A. I don't think they're well placed at all. They do a
22 fantastic job, they really do, but maternity and child
23 health nurses are not trained in mental health disorders.
24 They're a really excellent part of our overall service of
25 health care, but the maternity and child health network now
26 are funded much less than they used to be, so there's
27 specific appointment times - I mean, numbers of
28 appointments that women can access maternity and child
29 health nurses.
30

31 Maternity and child health nurses - this is feedback
32 that we receive - but they express often feeling an
33 enormous amount of work stress, just like, in terms of the
34 load that's placed on them because they don't - they're not
35 trained in mental health care at all.
36

37 I actually think it's - I think it's not right for us
38 as a - thinking mental health care - to put too much on to
39 maternity and child health nurses. They're a really
40 important part of the system but not, you know, not - we
41 shouldn't be pushing down onto them
42

43 CHAIR: Thank you.

44
45 MS COGHLAN: Thank you. May the doctor be excused,
46 please?
47

1 CHAIR: Yes, thank you very much.

2

3 <THE WITNESS WITHDREW

4

5 MS COGHLAN: Chair, is now a convenient time for a short
6 break.

7

8 CHAIR: Yes, let's adjourn.

9

10 **SHORT ADJOURNMENT**

11

12 MS COGHLAN: The next witness to be called is Shaun
13 McClare. I call him now.

14

15 <SHAUN DANIEL MCCLARE, affirmed and examined: [11.36am]

16

17 MS COGHLAN: Q. Thank you, Mr McClare. You've provided
18 a statement to the Commission?

19 A. Yes, I have.

20

21 Q. I tender that statement. [WIT.0003.0009.0007] You're
22 a principal of Kalinda Primary School?

23 A. Yes, that's correct.

24

25 Q. Whereabouts is Kalinda Primary School?

26 A. In Ringwood.

27

28 Q. How many students do you have there?

29 A. Approximately 580 students.

30

31 Q. Just in terms of the types of issues or challenges
32 that the students might face at that school, is there
33 anything particular about what they might experience?

34 A. Yep. So Kalinda is a fairly middle-class school. The
35 data suggests that socioeconomically students are
36 reasonably advantaged, with a small pocket of families from
37 English as a second language background.

38

39 However, just like any primary school, we have
40 students who face issues such as depression, anxiety, a
41 small number of students with suicidal ideation. The
42 issues faced by the students at Kalinda are quite typical
43 of students across the state.

44

45 Q. In your statement you say:

46

47 "Much of our work [and this means your work

1 at the school] in mental health is focused
2 on building a child's resilience to help
3 them when they may encounter greater
4 challenges when they get to high school."
5

6 A. Absolutely. So, the issues to do with mental health
7 come out a lot more within a secondary setting and the
8 challenges are a lot greater. Part of the role of a
9 primary school is to, in the best possible way we can as
10 educators, prepare our students for those challenges that
11 are ahead, and developing their sense of resilience and
12 giving them the wellbeing skills and capacities to be able
13 to face those challenges and seek help and seek advice and
14 get through challenges in high school and beyond, is a
15 really important part of our role as primary school
16 educators and educators across the whole system.
17

18 Q. Can I ask you specifically about the Maroondah
19 Positive Education Network?

20 A. So, in about 2016 the Maroondah Principals Network,
21 which comprises of principals of public, primary and
22 secondary schools in the Maroondah region, along with the
23 Maroondah City Council and the Department of Education,
24 formed a partnership to work on improving the wellbeing
25 outcomes for young people throughout the Maroondah area.
26

27 This work came off the back of a Maroondah youth
28 wellbeing survey which was commissioned by the Maroondah
29 City Council, was done in conjunction with the University
30 of Melbourne, and the survey was implemented across
31 schools, so the data coming out of that survey was one of
32 the big drivers to actually getting the network formed and
33 that partnership developed.
34

35 Q. What was the nature of that data that led to those
36 developments?

37 A. The data showed - and the survey collected data from
38 students from Year 5 through to the end of high school -
39 and it showed there was increasing levels across all
40 schools in the area, increasing levels of anxiety,
41 depression, other health issues such as lack of sleep,
42 stress, issues with worsening attendances as students got
43 older through school; they were some of the general issues
44 that were identified in the survey.
45

46 Q. What did that give rise to, if you can focus on the
47 Maroondah Positive Education?

1 A. So, the Maroondah Positive Education - the Maroondah
2 principals really came together, and as a group of
3 principals, formed a collective vision of working on
4 improving the wellbeing of all students within Maroondah
5 schools and this led to the partnership, where we're
6 actually being able to do some proactive work in developing
7 the skills and capacities of our skills to improve the
8 wellbeing of these students.

9
10 Q. Is that what the Maroondah Positive Education Network
11 is?

12 A. Yes, absolutely.

13
14 Q. And so, that's about increasing wellbeing and
15 educational outcomes for students?

16 A. Yes, it is. Yes, it is.

17
18 Q. That's through implementation of a Positive Education
19 program?

20 A. Yep, so the Maroondah Positive Education Network,
21 which was formed in approximately 2016, worked together to
22 implement Positive Education throughout the network. 26
23 schools, along with the Maroondah City Council and the
24 Department of Education, were dedicated to implementing
25 Positive Education throughout all of our schools.

26
27 Positive Education is an approach to look at wellbeing
28 of students where we're not just focusing on students who
29 have high levels of need when it comes to wellbeing or
30 mental health, but looking at the overall mental wellbeing
31 of all students and staff in a proactive way through
32 developing wellbeing literacy of staff members, through
33 being able to develop a culture within the schools where
34 wellbeing outcomes are valued just as highly as academic
35 outcomes, and that it's really important that we see the
36 two as intrinsically interwoven; that when we improve
37 wellbeing outcomes, that will improve academic outcomes,
38 and when we're doing things better academically, it also
39 improves wellbeing outcomes.

40
41 So, it's trying to move for the schools in the
42 Maroondah network, the focus from not just focusing on
43 numeracy and literacy outcomes, but really making sure
44 wellbeing has an equal footing with the importance in what
45 we do and the work we do with our staff and the
46 professional learning we focus on.

1 Q. So, you're looking at the way in which education is
2 delivered rather than implementing a program; is that
3 right?

4 A. Absolutely. So, Positive Education gives us a
5 framework for how we deliver wellbeing and how we teach
6 throughout our schools. It is not a program where you can
7 just learn how to do Positive Education and go in and do a
8 half hour class once a week.

9

10 It gives us a framework to focus on things that are
11 really important for student wellbeing, such as positive
12 relationships, meaning, gratitude, positive emotions,
13 developing those skills and capacities amongst staff
14 members, and then each school looking at their own unique
15 setting and circumstances and being able to then develop
16 curriculum and programs that are going to meet the needs
17 for their students under the umbrella of Positive
18 Education.

19

20 Q. Okay, so the needs of Kalinda Primary School for
21 example might be different to the needs of a different
22 primary school?

23 A. Absolutely. Whilst there will be a lot of crossover
24 and there will be a lot of similarities - it may be the
25 size of the school, it may be the demographics of the
26 school are different - so it's important that we are able
27 to work together collaboratively, because there's a lot of
28 power in that, there's a lot of sharing of experience and
29 expertise, but at the same time we have to really focus on
30 what we need to deliver in each school and where the
31 correct starting point is with the work.

32

33 Q. And so, there are various modules that you can focus
34 on?

35 A. Absolutely. So, initially we worked with Geelong
36 Grammar; Geelong Grammar has a lot of experience with
37 Positive Education and we looked at doing a lot of training
38 with them in looking at a number of different models, and I
39 might refer to my statement about the modules that were
40 developed to focus on.

41

42 So, the modules that we looked at developing were on:
43 character strengths, positive emotions, engagement, growth
44 mindset, positive relationships, meaning and purpose,
45 strength-based coaching, health including sleep and
46 nutrition, and brain breaks.

47

1 So these modules were developed and then schools are
2 able to access and work with their own staff in
3 professional development to build expertise amongst their
4 staff members in these different areas, and then schools
5 are able to develop plans and build curriculum around those
6 areas.

7
8 Q. And so, one of the focuses is on building staff
9 wellbeing, which then is perceived to have a positive
10 impact on the children?

11 A. Absolutely. So, since the start of the work we did in
12 the Maroondah Positive Education Network, we certainly had
13 a strong focus on having a focus on learning it, living it
14 and then leading it.

15
16 So we knew that it was really important to have staff
17 being able to see the impact of particular strategies
18 around wellbeing and how it could impact on their own lives
19 before they were actually going ahead and looking at
20 educating their students about these strategies.

21
22 Also, on the other hand, we know that, if staff have a
23 higher level of wellbeing, that will create a culture and
24 an atmosphere which is going to enhance the wellbeing of
25 all students throughout the school.

26
27 I think what is a really powerful part of what we're
28 doing in the network and what we're continuing to do, is
29 that, we are not ignoring the wellbeing needs of the staff
30 and, just like in any career, there are lots of unique
31 challenges that come in education and, if we can really
32 support our staff and support their wellbeing and their
33 mental health, that's going to create a better environment
34 for all students and have a great impact in the long run.

35
36 Q. And so, Kalinda Primary School has had Positive
37 Education influencing its program since 2016?

38 A. Correct.

39
40 Q. You haven't been there that whole time?

41 A. No, I've been working in the network since 2016.
42 Prior to Kalinda Primary School I was at Marlborough
43 Primary School, so I had been working in the network but
44 I've only been at Kalinda Primary School since April
45 this year.

46
47 Q. So, what have you seen though in terms of the impacts

1 on either the previous school or at Kalinda?
2 A. Firstly to my previous school, Marlborough Primary
3 School, I saw a real change in the language that staff
4 used; a focus on a strengths-based approach to wellbeing
5 issues.

6
7 So, it wasn't focusing entirely on the negative issues
8 that were faced with students, it was looking at how we
9 could build their strengths and their level of resilience
10 to focus on, you know, facing the challenges that lay ahead
11 in life.

12
13 At Kalinda Primary School, being there a term so far,
14 I can see there's a really strong focus on wellbeing in
15 line with the focus on, you know, academic performance at
16 the school.

17
18 We have two HOPE Leaders, so that's Head of Positive
19 Education Leaders throughout the school, we have wellbeing
20 leaders amongst our students, and there are a number of
21 fantastic programs that are going on underneath the
22 umbrella of Positive Education that shows that at Kalinda
23 we're really focusing on wellbeing in a very broad yet, I'd
24 say, well researched and strategic way.

25
26 Q. Can I ask you about two particular programs?

27 A. Yes, absolutely. So, at Kalinda at the moment a
28 couple of programs that are going on under that umbrella:
29 one of them is, in the last 12 months we've implemented the
30 Play is the Way program at the school. Play is the Way is
31 a program where students take part in games and role
32 playing activities that put them inside challenging
33 situations. Then, during those games, a teacher is able to
34 pause the game and have the students reflect on how they
35 reacted emotionally to the challenges.

36
37 The students then are able to discuss how they could
38 approach that challenge differently in the future; what the
39 particular game or challenge really - how it impacted on
40 them, how it impacted on those around them, and then we can
41 focus on the students' ability of resilience and wellbeing
42 and also student relationships, so it's a fantastic program
43 that can look at some of those big umbrella items within
44 Positive Education about positive emotions and positive
45 relationships.

46
47 That's implemented for all students throughout the

1 school, so that's across every classroom from Foundation
2 through to Year 6 and is part of our curriculum and part of
3 our timetable part of what we deliver.
4

5 Another program we started recently throughout the
6 last term is the Rock and Water program. This program is
7 delivered for 60 students, so it's a much more discrete
8 students. Those students have been selected for a variety
9 of different reasons. It may be that they are students who
10 are facing some wellbeing challenges, they may be showing a
11 lack of resilience, they may be having trouble with their
12 relationships out in the yard. But then there's also some
13 students in there, it may be that they show fantastic
14 leadership capacity and skills.
15

16 So there's a wide variety of students but they're
17 being selected for specific reasons. That program uses a
18 range of physical activities loosely based on martial arts,
19 so that really builds students' resilience, leadership and
20 relationship-solving issues
21

22 MS COGHLAN: Thank you. Chair, are there any questions
23 from the Commissioners?
24

25 CHAIR: Professor McSherry.
26

27 COMMISSIONER McSHERRY: Q. Just one question. I was
28 just wondering whether you were working with some of the
29 researchers to evaluate the framework and some of the
30 programs that you are doing?

31 A. Yes, absolutely. So, with Melbourne University, so
32 with the youth wellbeing survey that was implemented, just
33 in the last month we've also completed that survey again so
34 we'll be looking at the data there.
35

36 That's a tricky one because it's still in its first
37 few years so we don't really have a great amount of data to
38 see the success and the impact, and we know that cultural
39 and practice change within a school can be long, slow work.
40 But certainly, with everything that we do, we are always
41 collecting data and analysing that data too, to make sure
42 that we're being rigorous and we're not just - we're not
43 just having a go, we're making sure we're doing the right
44 work when we put the effort in.
45

46 CHAIR: Dr Cockram.
47

1 COMMISSIONER COCKRAM: Q. Hi, Mr McClare. Yesterday,
2 and I'm not sure if you're aware of the evidence we heard
3 yesterday from Georgie Harman, CEO of Beyond Blue, but she
4 talked about what I think is an alternative program that's
5 operating within the Education Department and across
6 different schools called Be You.

7
8 This sounds like quite a different program, what
9 you're describing to us today. Can you just articulate the
10 differences between the programs and why you and the group
11 of schools that you're working with chose Positive
12 Education?

13 A. That's a good question. So, I'm not that familiar
14 with the Be You program to be honest, but the rationale
15 behind choosing Positive Education was, there were a number
16 of principals within the network who had experience with
17 Positive Education in the past. Out of the work that
18 Martin Seligman has done with positive psychology and then
19 has been implemented into work such as Places at Geelong
20 Grammar, there's quite a lot of research and evidence out
21 there that shows that work has had a high impact, so the
22 decision was to head down that path as a network.

23
24 As a network of schools, we were very mindful of the
25 fact that, you know, we've got special development schools,
26 small primary schools, large primary schools, smaller high
27 schools, larger high schools, so whilst we're from the same
28 region, there still is quite a lot of diversity throughout
29 the schools so we're very mindful of not just getting a
30 program that we could fit in, we wanted to really work on
31 Positive Education as a framework for wellbeing, that each
32 school could then develop their plan, which could include
33 programs, and it can include lots of different programs
34 that are then put into the schools, but it's making sure
35 that, as a whole, we've got a framework with which we look
36 at wellbeing throughout the school.

37
38 MS COGHLAN: Thank you.

39
40 CHAIR: I've just got a few other questions I'd like to
41 clarify, thank you very much, Mr McClare. The first one
42 is, in the survey that you describe gave rise to this
43 initiative, I think it was for students aged in those
44 higher years of primary school and into high school, but in
45 terms of the issues you've identified as the principal and
46 with your colleagues, for children experiencing what you've
47 described as increased incidents of anxiety and depression

1 and a small number of students with suicidal ideations, has
2 that been across the whole continuum of primary
3 school years, from Prep to Year 6, that you see those
4 issues or are they concentrated in the latter years of
5 primary school?

6 A. I would say through my own experience but not with any
7 actual data, but through my experience it is in the latter
8 half. So, it really is in those later years of primary
9 school that we generally see those issues, yes.

10
11 Q. Can I just ask then, for those students for whom you
12 might be concerned about their wellbeing, as well as
13 building the overall resilience for all students, typically
14 what access to additional support and assistance would you
15 be able to seek for those students?

16 A. Absolutely. So, you know, as educators we don't think
17 that our teachers are mental health experts in any way, and
18 also as a principal I'm not as well, so it's really
19 important that we're able to access support from experts to
20 really help when there are students who are presenting with
21 mental health issues that are really concerning to us.

22
23 So, the first point of call generally within a
24 government primary or secondary school is to, in
25 conjunction with the parents of that student, is to put a
26 referral in to student support officers who work within the
27 department, so that can be psychologists, speech
28 therapists, a range of different services that are there.
29 They can then look at assessing a student and helping that
30 student and the family access further services as required.

31
32 Q. Do they also provide secondary consultation to you or
33 the classroom teacher about making sure you adopt
34 appropriate practices in relation to individual students?

35 A. Absolutely. So, the SSO officers come in and work
36 with schools and have established ongoing relationships
37 with the schools, so it's quite typical that you would have
38 the same psychologist, for example, come in and work at
39 your school one day per week, so you know this person quite
40 well, they're an established part of your staff.

41
42 And absolutely part of the work you're doing there is,
43 of course, assessment of a student, but then, it's
44 educating teachers to be able to give appropriate responses
45 and have the correct supports that are there to make sure
46 we can, you know, do our part in looking after the
47 wellbeing of those young people who may be at risk.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

As with all sectors, we would always love more support and more resources, and that's part of the ongoing nature of things, but there's a very clear process there for us to follow.

CHAIR: Great, thank you very much.

MS COGHLAN: Thank you, may the witness be excused?

CHAIR: Yes.

<THE WITNESS WITHDREW

MS COGHLAN: The next witness is Dr Richard Haslam and I call him now.

<RICHARD HASLAM, affirmed and examined: [11.56am]

MS COGHLAN: Q. Dr Haslam, I speak pretty quickly, and I fear that you might too, so let's try and keep the pace at one that can be followed. You've provided a statement to the Commission?

A. Yes, indeed.

Q. I tender that statement. [WIT.0002.0006.0001] Can you please state what your qualifications are?

A. I have a basic medical degree, the Bachelor of Medicine, Bachelor of Surgery, postgraduate qualifications in child and adolescent psychiatry, and in child and adolescent mental health. I'm qualified as a consultant paediatrician.

Q. What is your current role?

A. I'm Director of Mental Health, which is the department involved in mental health at the Royal Children's Hospital.

Q. Can I start by something you about CAMHS; that's a term that the Commissioners have heard and is often used. First of all, what does it stand for?

A. CAMHS stands for child and adolescent mental health services.

Q. And, what are they?

A. CAMHS services are team-based services made up of a number of disciplines set up to deliver care for children and adolescents, and indeed infants, with severe and

1 complex mental disorders.

2

3 Q. What age group do they service?

4 A. 0-18.

5

6 Q. How many regionalised CAMHS are there in Victoria?

7 A. There are 13 regionalised CAMHS services each with a
8 catchment area, eight of them regional and five
9 metropolitan.

10

11 Q. And all of them, apart from the Royal Children's
12 Hospital, are aligned with and governed by health services
13 that also provide adult mental health services?

14 A. That's correct.

15

16 Q. Another term that the Commission has heard is CYMHS.
17 Can you just tell us what CYMHS is?

18 A. So, over about the last 20 years a youth model of
19 mental health has come into place in Victoria and it offers
20 a focus on young people aged 15-25 years. It's evolved
21 from adult mental health models and is a significant
22 modification of those. Amongst other things, it aims to
23 improve access for a group of young people who have
24 traditionally had difficulties in gaining access to mental
25 health services.

26

27 CYMHS is a term for CAMHS services which have
28 incorporated youth mental health, and to differing degrees,
29 but which essentially cover an age range of 0-25.

30

31 Q. I'll come back to ask you about that later. Can we
32 just focus on, for the moment, the Royal Children's
33 Hospital and the breadth of services provided by the Royal
34 Children's. If you could just outline what they are.

35 A. Certainly. So, I guess we might use two umbrellas:
36 one is clinical and the other is collaborations. So, we
37 provide a very broad range of clinical services, from
38 inpatient care for young people 13-18 years of age, with
39 serious or highly risky mental health conditions.

40

41 We provide community mental health care based from
42 three clinics around Western and Northern Melbourne, which
43 is probably the predominant means by which Child and
44 Adolescent Mental Health Services are delivered.

45

46 We offer a fairly wide range of specialist clinics
47 based at the Children's, many of which have a state-wide

1 remit, for example infant mental health, gender services,
2 eating disorders, neurodevelopment and so forth.

3
4 We provide mental health care for children who are
5 inpatients of the hospital, including the emergency
6 department where we've seen a remarkable rise in the rate
7 of presentations of young people with mental disorders and
8 mental health symptoms, particularly after hours.

9
10 From a collaborative point of view, and I guess this
11 is something we'll talk about a little more later, we have
12 a number of services that we take pride in. We, for
13 example, offer a School Refusal Program in partnership with
14 the Travancore School, which is called Inter-School. We
15 provide, like many other CAMHS services, the CASEA program,
16 C-A-S-E-A, which is a universal targeted and specific, if
17 you like, intervention for children in Prep to Grade 3 in
18 primary schools aimed to reduce the incidence of conduct
19 problems and conduct disorders.

20
21 We have collaborations with, say for example, maternal
22 and child health nurses in our new program called "Bubs in
23 Mind" in two Local Government areas.

24
25 We also take part in mental health promotion, which is
26 sort of right up the other end of the spectrum, if you
27 like, and we're very proud of the 21 years of our Festival
28 For Health Living which provides mental health promotion
29 and building resilience through the arts.

30
31 Q. There's also some new collaborations that are
32 occurring at the moment?

33 A. Yeah, our CAMHS service was fortunate to receive
34 growth funding over the last couple of years, and we
35 dedicated most of that to a range of programs which were,
36 again, about capacity building and collaboration.

37
38 So, for example, with the Wadja Family Place, which is
39 an Aboriginal Mental Health Service within the Royal
40 Children's Hospital, children with developmental
41 disabilities, children who are from a refugee background
42 and who have suffered trauma, children who were in
43 out-of-home care. So, we targeted those collaborations and
44 that clinical work to really reach into and build mental
45 health capacity in those really under-serviced areas.

46
47 Q. Can I ask you specifically about one of the specialist

1 services that you mentioned, and it was the - I think it's
2 the Infant Mental Health Team; is that the correct name?

3 A. That's correct.
4

5 Q. You said earlier on that CAMHS provide services to
6 children aged 0-18 years, or it has the capacity to. But
7 is it the case that, in the past, little attention has been
8 paid to that 0-4 age bracket?

9 A. Yeah, I think that's very true. Probably in the
10 community, but perhaps also amongst health providers,
11 there's a neglect or a lack of appreciation of the presence
12 and the severity of mental illnesses and symptoms of mental
13 health problems which are present in infants. And by
14 infants I'm using the term for 0-4, but it could equally be
15 applied for 0-2 as well.
16

17 Q. And so, how has the Royal Children's Hospital
18 responded to that?

19 A. So our response, and I'd like to think that we're
20 really world-leading in infant mental health, our response
21 over time has been one of clinical services. So, we
22 provide clinical services for children in the hospital and
23 who have left the hospital who've suffered from, what we
24 use the term of medical trauma, which is the result of
25 often very severe congenital or medical problems early in
26 life. And, as you can imagine, the stress for children,
27 infants, and also for their parents, is enormous with some
28 of the required medical interventions and surgical
29 interventions that infants might experience.
30

31 We've also provided care for children who have
32 suffered from what we call adverse childhood experiences,
33 if you like, and so, they might have been born in a family
34 where there is substance use, parental mental illness,
35 family relationship difficulties, family violence, these
36 sorts of things. So, children in that kind of environment
37 are far more likely to experience traumatic symptoms as
38 well as anxiety and depression.
39

40 And we also see infants who develop anxiety and
41 depression just like children, just like adolescents and
42 just like adults. So, we provide those clinical services
43 and, as well as that, we've provided training for
44 paediatricians, for child psychologists, and widespread
45 training for a number of other disciplines as well.
46

47 Q. Is that just within the Royal Children's Hospital

1 context or is that training more broad?

2 A. The training is state-wide and we run, for example, a
3 two-day training each year which is widely subscribed to
4 and typically sells out.

5

6 Q. Can I turn now to ask you about some challenges that
7 might be faced in this sphere, particularly in relation to
8 the Child and Adolescent Service model. Can we start with
9 the idea that there's a mismatch between inpatient care and
10 community service providers, or the provision of services
11 in the community. Can you just expand on that?

12 A. Okay. So, there are four inpatient units for
13 adolescents, essentially aged 13 to their 18th birthday in
14 metropolitan Melbourne which provides services for
15 Victoria. There are also two inpatient units for children
16 under the age of 13 in Victoria. There are also youth
17 mental health wards for an older age group.

18

19 To an extent there's a mismatch between the provision
20 of outpatient care and inpatient care. A good example is
21 the ward at the Royal Children's where, because of
22 catchment - well, because of age cutoffs that exist for
23 outpatient care, the vast majority of young people admitted
24 to our ward are receiving the community care from either
25 Orygen Youth Health if they're over the age of 15, or from
26 regional providers; so, we provide inpatient care for three
27 large parts of western and southern Victoria.

28

29 So in fact, most of the young people in our Banksia
30 ward, our adolescent ward, are receiving community
31 treatment from another service, whether it's a youth mental
32 health service, a CYMHS or a CAMHS. And that's a problem
33 because inpatient care really is generally a small period
34 of time in a course of outpatient treatment. The
35 definitive treatment of most child and adolescent mental
36 disorders is outpatient treatment.

37

38 So, it's important that there's coherence between the
39 models of care, and also there's clear communication
40 between inpatient and outpatient, and that's not well set
41 up in arrangements such as we have at the Children's and to
42 some extent in other services.

43

44 Q. Just moving on then to another challenge; this is in
45 terms of the way that perhaps CAMHS were initially
46 established, and the idea that they're really bolted on to
47 a system that's designed for adults. Can you just explain

1 that?

2 A. Yes. So, I guess that CAMHS services, apart from the
3 Royal Children's, CAMHS services are part of, and typically
4 all ages, mental health service that's regionalised, so
5 there's a logic in terms of a catchment area, but the
6 result, in my view, is a rather fragmented and devolved
7 system of CAMHS services.

8

9 I think that the delivery of mental health services in
10 Victoria is really predicated on adult mental health models
11 and adult mental disorders, mental illnesses in the first
12 instance. So, in my view, structural issues like catchment
13 areas and models like the recovery model or a case
14 management model are devised predominantly for adult mental
15 health services and then there's an attempt to make them
16 work for child and adolescent mental health services.

17

18 Certainly, we see that funding opportunities and
19 funding guidelines are typically directed for the much
20 larger adult mental health services; and quite often
21 funding initiatives, such as the Multiple and Complex Needs
22 Initiative, is specifically only for people over the age of
23 16 or over the age of 18 in some other policies.

24

25 Q. Can I ask you also, and just picking up on something
26 you've said in your statement, that you consider that there
27 are three dimensions which represent the range of mental
28 health problems for children and adolescents and therefore
29 represent the needs of the system. Can you just elaborate,
30 first of all, on what those three dimensions are?

31 A. Sure. So, if one pictures a cube in one's mind's eye:
32 so, what we have is a range of ages: clearly we have
33 children, we have infants, we have children, we have
34 adolescents, all with very different settings, all with
35 very different needs, all with very different degrees of
36 independence. Clearly, devising a mental health system for
37 infants will be in some ways very different from the way
38 one might devise it if one has the patient or the young
39 person in mind, very different from that for a 15-year-old
40 or an 18-year-old. So, that's one of the dimensions, if
41 you like.

42

43 The second would be that there are a range of
44 conditions or disorders, or symptoms which present in
45 childhood: anxiety and depression, for example, eating
46 disorders, psychoses, conduct problems, neurodevelopmental
47 difficulties like attention deficit hyperactivity disorder

1 or autism spectrum disorder. So, there's actually a very
2 broad range of the sorts of conditions which fall into
3 mental health and mental ill-health.
4

5 Then the third dimension, if you like, is that of
6 severity. So, we see great degrees of range in severity:
7 we might see a child with anxiety who has difficulty
8 speaking in front of class, we might have another child
9 with anxiety who's been unable to go to school for two
10 years. So, we've got a range of ages, we've got a range of
11 conditions, and we've got a range of severity.
12

13 Q. You say in your statement, in relation to those three
14 dimensions you've described, that they're "a challenge to
15 developing a service system for mental disorders in
16 isolation." So, can you just expand on that please?

17 A. Yeah, I might just make the point that, as we've seen
18 from the second and most recent national survey of child
19 and adolescent mental health and wellbeing, that somewhere
20 close to 15 per cent of children will have symptoms of a
21 mental disorder or a mental illness. So, a specialist
22 mental health service system simply won't be able to manage
23 with that degree of prevalence.
24

25 If we think about a cone or a triangle with the
26 specialist services at the top or the top part of that,
27 15 per cent is an enormous number of children and
28 adolescents, so that's probably the context I might add.
29

30 In terms of the severity, most of the young people
31 with mental health problems, mental illnesses or mental
32 disorders will have the milder or more moderate
33 difficulties, and so, a mental health service system, a
34 specialist system in isolation isn't going to be designed
35 for that large - which is a large number - of children who
36 have mild and moderate difficulties.
37

38 Q. What about the expression of the child's voice and the
39 parent's voice, and how a model responds to that?

40 A. Yeah, I touched on this in talking about infants, but
41 I think that the child's voice when it comes to mental
42 health problems is, again, often a little minimised. We
43 know that generally the best informant, the best person to
44 explain the degree and nature of anxiety and depression is
45 the person themselves; in contrast to behavioural
46 difficulties, like conduct problems, where probably the
47 best informant is going to be educators or parents.

1
2 So I think there is to an extent a minimising of
3 mental health problems in childhood as part of growing up,
4 and so, I guess the child's voice isn't well represented
5 because they're so dependent and because there's this
6 perhaps systematic underplaying of the nature and degree of
7 mental health problems that children and adolescents might
8 experience.

9
10 Q. You see that in some parents, for example, there's a
11 perception that their child might grow out of a certain
12 problem they're experiencing?

13 A. Yeah, this is compelling results from the National
14 Child Health Poll which the RCH conducted or continues to
15 conduct, but conducted in mental health last year, that
16 many parents feel that infants don't have mental health
17 problems and children - and they struggle to appreciate
18 that children might also experience enduring mental health
19 difficulties, and certainly they report that they wouldn't
20 know where to turn in a significant minority of this
21 representative sample of Australian parents.

22
23 Q. Can I ask you about that in terms of knowing where to
24 turn and ask you some further questions about difficulty
25 accessing services when needed. Can I start by asking you
26 about this prevalence issue you've already raised. Do you
27 agree with this proposition: that the prevalence is too
28 high for 13 CAMHS to meet, for example?

29 A. I do.

30
31 Q. What about waiting times?

32 A. So, my observation would be that, in a situation - and
33 we'll possibly talk about this later - of what I term "the
34 missing middle", an absence of --

35
36 Q. That's next.

37 A. Great. An absence of providers who can meet the
38 demand for and feel authorised and supported to meet the
39 demand for addressing mental health problems that are of a
40 mild and moderate severity, CAMHS services, what we see in
41 health is that the work sort of moves upwards if there's
42 nowhere for it to be met in the first place, so children
43 and adolescents will be presented to CAMHS services even
44 with mild difficulties, and CAMHS services will spend a
45 significant amount of their time triaging or sorting
46 through, finding pathways for children with mild or more
47 moderate difficulties.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. And, what's the result of that for CAMHS?

A. So, the result is that we see, I guess, rationing; we see catchment areas being strictly adhered to; we see referral criteria that rely on severity and acuity. So, children are able to access a CAMHS service in an emergency or in an urgent situation, but waiting times might be as long as 12, 16, 18, weeks for a regular referral of a child who's even got over that referral bar.

Q. In terms of this missing middle, what should be there?

A. So, at the moment the middle, if you like, is predominantly Federally funded, a Commonwealth funded fee for service providers, like paediatricians, Better Access psychologists and a range of other providers, and my observation is that there's a maldistribution of those, such that it's really not a system, it's a series of providers each in isolation.

So, the missing middle is the lack of or the paucity of, but also the maldistribution of solo providers of child health and child mental health, such as paediatricians, psychologists, and of course school welfare staff and school counsellors, school psychologists and so forth. There's a shortage of them, but also a maldistribution.

What we know is that the rates of mental health problems, mental illnesses, differ in different parts of Victoria. And we know that where, for example, there's lower socio-economic predominance, that there are much higher rates of mental health problems, and yet, we don't see what we call proportionate universalism where services are provided in proportion with need. Instead we see CAMHS services provided on a more or less per capita basis and then a Federally funded system or series of providers which attempt to meet the middle.

Q. Just picking up on that funding question, what do you say then about the adequacy of funding in the context of prevalence that you've raised?

A. So, I think it's demonstrated, from the recent Victorian Auditor-General's Office audit of child and youth mental health services, and indeed access to mental health services, that funding is really insufficient, even for the prevalence of serious, severe mental illnesses in all ages.

So, even for the most pointy end if you like, or

1 serious, the funding is insufficient. But, as I said, the
2 presence of and the affordability of private providers is
3 really quite variable across Victoria, and I suspect is -
4 they're even more difficult to access in regional Victoria
5 than they are in metropolitan Melbourne.
6

7 Q. What about monitoring in terms of, what monitoring is
8 there for CAMHS?

9 A. Predominantly CAMHS are funded on the basis of input,
10 so activity, and it's a little bit like the fee for service
11 system, that one is reimbursed from MBS for the time taken
12 rather than the outcomes that ensue.
13

14 Q. So what's your view then on whether it should be
15 outcome-based?

16 A. So I think measurement-based care and funding on the
17 basis of notions such as access for vulnerable groups,
18 outcomes, the use of evidence-based interventions, these
19 are all things which are likely to lead to a much more
20 effective and impactful CAMHS service.
21

22 Q. Does it then offer the best means to improve services?

23 A. Yes, I do. I think that funding for outcomes - as I
24 said, access for vulnerable groups, collaboration with that
25 middle, the missing middle, with other providers, with
26 health providers/schools, these are all things which, if
27 there are funding targets attached then it's far more
28 likely that services will evolve to develop those services,
29 even if we have a devolved system of 13 CAMHS.
30

31 Q. Can I take you now to some specific recommendations in
32 relation to system design. Before I get to that though,
33 can I just ask you about the importance of early
34 intervention. You say in your statement that:
35

36 "Mental disorders tend to be persistent or
37 recurrent, and accumulative. There is a
38 snowballing effect when mental disorders
39 develop and accrete with other medical,
40 mental health and social difficulties."
41

42 Can you just expand on that in terms of looking at an
43 effective system?
44

45 A. I think there are powerful reasons to intervene early
46 which are probably pretty obvious to all of us, but there
47 are - as well as the cost-effectiveness of intervening

1 early, for example through parenting interventions or more
2 simpler shorter interventions because of less - a lower
3 severity, I think there's an economic impact from failing
4 to intervene early - children become adults and become
5 parents, of course.

6
7 What we typically see is that, as I think as other
8 testimonies have provided, we see that there's an
9 accumulation of difficulties. So, again, adverse childhood
10 experiences, mental health difficulties that might also be
11 present in other members of the family. So, intervening
12 early for children whose voice is not often easily heard is
13 valuable for a whole lot of reasons.

14
15 Q. Taking you now to specific recommendations, one of the
16 things that you've already touched on is the idea of this
17 missing middle, and an alignment with primary care system
18 and building capacity. Is that one key change that you
19 would recommend?

20 A. Yeah, I think that, rather than having a specialist
21 service that's potentially a little bit isolated, I think a
22 proportion of CAMHS or CYMHS services time should be
23 specifically around building capacity. There's a range of
24 things I could refer to, and I think I have in my witness
25 statement, that the Children's is seeking to do and is
26 doing, but I think there has to be a devotion to and a
27 commitment to building the capacity and providing available
28 support for, for example, paediatricians, and I've cited
29 the example of the Massachusetts Child Psychiatry Access
30 program providing direct sustainable supervision,
31 consultation for paediatricians dealing with these sorts of
32 difficulties.

33
34 Q. Can you just expand on that, that example?

35 A. Yeah, so the MCPAP's been running for probably 10 or
36 20 years. It obviously started in Massachusetts but it's
37 used in a number of states now. One of the parts of that
38 is that there are child and adolescent psychiatrists who
39 are available for consultation generally within 30 minutes
40 for paediatricians who might have a - who are essentially
41 primary care providers in the US.

42
43 Q. Is that a phone contact, do you mean?

44 A. Yes.

45
46 Q. Sorry, go on.

47 A. So, to be able to provide advice and recommendations,

1 for example about medications or therapies or treatment
2 pathways.

3
4 Q. So, would that include referrals?

5 A. Sure, yep.

6
7 Q. Just in relation to, like, a further recommendation:
8 the idea that there needs to be greater recognition of the
9 special needs of child and adolescent mental health in
10 system design; if you could just expand on that?

11 A. As I mentioned earlier, I think conveying the voice of
12 children, the participation of children, in the care that's
13 provided and the way the system's designed is something
14 that we need to purposefully do. It's something that's
15 been done quite well in youth mental health services, and
16 indeed there are paid peer support workers in adult
17 services, but I think we can do better to present the needs
18 of children for children.

19
20 Q. One of the things you say in your statement is:

21
22 "While the community may now better
23 understand mental disorders for those aged.
24 Between 15 to 18 years old as well as
25 issues such as youth suicide and drug use,
26 the impairment of mental illnesses
27 occurring early in life are often minimised
28 and misunderstood."
29

30 So, is what you're saying seeking to address that area
31 that is minimised and misunderstood?

32 A. Yeah, I think we can strengthen both in health
33 providers and in the community the understanding of the
34 impact and the presence of mental illnesses and mental
35 health problems in children; children who might have other
36 adverse experiences, might have health problems, or might
37 simply have a range of mental health difficulties. So, we
38 can simply do better with that. The term is used of
39 "mental health literacy for the community".
40

41 There are a range of resources such as the Raise Your
42 Children Network which provide, you know, evidence-based
43 and useful information for parents, but there's much more
44 that we could do to support parents to appreciate and
45 understand mental health difficulties in their children,
46 and the same goes for educators and the same goes for
47 health and welfare providers.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. Can I ask you now about the point of view that you have which is to amalgamate CAMHS. So, if you can just explain that, please?

A. So, I think a devolved or essentially fragmented system of 13 separately governed CAMHS services is probably not how you would design things if you wanted to have consistency, if you wanted to have workforce development, if you wanted to have evidence-based care spread across all of those services.

So, I think we've found ourselves with 13 separate CAMHS services, but I think that there are problems with that. I think there's a gradient of services that are available across catchment areas, and I think in terms of critical mass for the workforce and from the point of view of introducing evidence-based interventions, common pathways, consistency of care, it would make much more sense to pattern from, for example, children's cancer or paediatric rehabilitation where we've approached things from a state-wide perspective.

I do think that the missing middle is child and adolescent providers, health providers, paediatricians, general practitioners, psychologists and so forth, and the better that CAMHS services are aligned, or a single infant, child and adolescent mental health service is aligned with those services, the better for children.

Q. In terms of evidence-based interventions in child and adolescent mental health, one of the things you refer to in your statement is the example of what's going on in Canada, in Ontario. Can you just explain that?

A. Yes, I've referred to the Ontario Centre of Excellence in Child and Youth Mental Health, which is really a remarkable organisation. Ontario has a population of nearly 15 million, and the Centre of Excellence is partly about knowledge translation and partly about disseminating and implementing evidence-based treatments, but it's very much involved in that implementation part.

So there's developing policies, policy advice, there's developing evidence and then there's making sure that it's implemented using meaningful outcomes and having them employed in mental health services. So, it's really a centre for the whole state to improve the uptake of evidence-based interventions which, after all, are the most

1 likely things to help children and youth.

2

3 Q. Can I ask you about your thoughts on the resolution of
4 the youth mental health model, and what I'm referring to
5 there is, you've given evidence about the CAMHS service
6 covering children 0-18 years, but also the CYMHS service
7 which is, is it 15-25 focused?

8 A. The CYMHS would technically be 0-25 in most cases,
9 yes.

10

11 Q. Zero. Can you just explain what you mean by
12 resolving, if there is tension, between those two services?

13 A. So, I think there's a - as I mentioned earlier,
14 there's been the presence of a youth mental health model in
15 Victoria for probably 20 years, and to some extent it's
16 been taken up in the use of, for example, child and youth
17 mental health services in a number of other ways, and
18 certainly interventions, or services like Headspace are a
19 great example of that.

20

21 I think it's laudable that there's been attention to
22 the mental health needs of people over the age of 15.

23

24 I think that it hasn't entirely been resolved, and
25 certainly in the case of a paediatric or a child and
26 adolescent model there are still - there's an extent to
27 which there are unresolved inconsistencies. And so, the
28 example of the inpatients and the outpatient care in the
29 North and Western Melbourne was one that I gave a little
30 earlier.

31

32 So I think it's really important that the community
33 care is aligned with inpatient care, and at the moment that
34 isn't necessarily the situation that we have.

35

36 I think that, from a paediatric perspective, child
37 health and children in families, which is most young people
38 under the age of 18, is to some extent, if not at odds,
39 then in some sort of creative tension with a youth mental
40 health model.

41

42 I think that one of the things that I'm aware of in my
43 region, or in my department, is that the acuity or the
44 severity or the risk of young people presenting with mental
45 health problems who are perhaps over 15 tends to be more
46 acute and more risky; so, for example, if you think about
47 suicidal behaviour.

1
2 So, the result is that, if one has a service where
3 there are choices to be made about allocation of funding,
4 inevitably there will be an allocation of funding to where
5 that risk sits; so that's something that we've done with
6 funding emergency department mental health staff where we
7 might otherwise have devoted that to community outpatient
8 care.

9
10 So, I think it would be interesting to examine, in say
11 for example a child and youth system, which is 0-25, the
12 extent to which young people, children and adolescents who
13 are in the younger age bracket, are continuing to receive
14 parity of service and continue to have their various and
15 particular needs met.

16
17 It's very important that all ages are able to gain
18 access to appropriate settings and services and trained
19 providers with evidence-based treatments and measurement of
20 outcomes and so forth. But it's also very important that,
21 if we're having a 0-25 model, that we make sure that we
22 recognise the various needs and the nature of serious
23 mental illnesses in children and adolescents at the same
24 time as the serious and impairing mental disorders that
25 might present themselves in young people; that is to say,
26 people over 15.

27
28 Q. Thank you, doctor. Are there any other key
29 recommendations that you'd like to voice before the
30 Commissioners?

31 A. We've touched on it a little, but I think that general
32 practitioners, schools, paediatricians are very much at the
33 frontline of this very high prevalence of mental health
34 problems, and I think that it's important that - you know,
35 we use the phrase "no health without mental health" - I
36 think it's really important that general health providers
37 are supported to see mental health as part of their work,
38 not as something for another discipline or another area.

39
40 It's very important, given the prevalence and the
41 overlap of medical and mental health difficulties, or
42 physical and mental health difficulties I should say, that
43 those service providers, those health providers see mental
44 health as very much part of what they do.

45
46 And I think CAMHS or CYMHS as specialist mental
47 health, as I said earlier, really needs to be expected and

1 tasked to support, like that Massachusetts program I
2 mentioned, to support those paediatricians and others.

3
4 I also think that there's a case that could be made
5 for community paediatricians, as there are in other
6 jurisdictions in Australia which are co-located with mental
7 health providers, so salaried paediatricians, if you like,
8 to provide accessible services for children and families.

9
10 Q. Can you give an example of where else they're
11 provided?

12 A. New South Wales, would be an example.

13
14 Q. Thank you. Anything further, doctor?

15 A. That's all.

16
17 MS COGHLAN: Thank you. Chair, any questions from the
18 Commissioners?

19
20 COMMISSIONER COCKRAM: Q. Dr Haslam, I just want to
21 revisit this issue of the youth model and the CAHMS model.
22 It's, as you say, quite a contested space and just getting
23 further clarity from you on your thinking.

24
25 In a model where you're suggesting an amalgamated
26 CAMHS service, and in a further description you were
27 describing the increased need for resources around over
28 15-year-olds, the impact that has on the rest of the
29 system, is it your suggestion, let's say, rather than
30 recommendation, that there is something important about
31 that 15-year-old point, noting that there is no age
32 point which will be universally appropriate for any
33 community, but are you describing that as being potentially
34 a significant point in the developmental experience of
35 children and adolescents and in service system design?

36 A. It is indeed contested, and I suppose my conceptual
37 proposition is that fragmented child and adolescent mental
38 health services, or a devolved system as we have, is
39 probably not the way you would design things for consistent
40 and best practice.

41
42 I think the age of 15 is probably conceived because
43 around 14 to 15 is where psychotic disorders start to
44 become a lot more common. I'm not sure of any particular
45 reason why 15 otherwise is a particularly logical seam or
46 separation point, but I completely agree that there is no
47 single age. You know, we think of adolescence as going

1 right through, and brain development of course right
2 through into the early 20s, so in many ways any age that is
3 sort of selected will be supportable and also could be
4 criticised.

5
6 From a paediatric point of view, there's not really
7 something that happens at 15 that's any different, and so,
8 chronic medical disorders and medical difficulties don't
9 really - you know, the physical phenomena of illnesses
10 don't change.

11
12 What is also different at 15, is that, that's around
13 when we're starting to contend with issues of capacity and
14 consent for treatment and so forth. So, to that extent, I
15 think as well as the onset of psychotic disorders, I think
16 that 15 has some sort of face validity or some merit. But
17 from a paediatric health point of view, from the training
18 of practitioners, child and adolescent psychologists, child
19 and adolescent psychiatrists, 15 doesn't particularly make
20 a whole lot of sense.

21
22 I think there'd be a lot to be said for having fewer -
23 a lesser emphasis on catchment areas and a much lesser
24 emphasis on strict ages, and more on what's the right
25 service for this young person who's presented in this way.

26
27 I just think it's important to recognise that many of
28 the young people who might present to specialist mental
29 health services around 15 or 16 have actually had
30 unrecognised mental health difficulties such as anxiety and
31 depression, ADHD and so forth, in earlier life; it's just
32 that they've presented to mental health services for the
33 first time with perhaps a psychosis or a depression or
34 self-harm or something of that sort

35
36 COMMISSIONER COCKRAM: Thank you.

37
38 CHAIR: Q. Dr Haslam, I've got three issues I'd like us
39 to address. The first is, in your statement to us you
40 talked about, "The prevalence of low to moderate severity
41 mental illnesses has been fairly stable, but there is a
42 clear rise in presentations of depression and anxiety in
43 adolescents which is associated with increasing rates of
44 self-harm and suicide", and you talked, I think, about "the
45 gains we've made has declined" in terms of that.

46
47 But you also went on to say that this increasing

1 presentation and the presentations at EDs is
2 contemporaneous with the arrival of the smartphone. Could
3 you just talk a little to what you think about that issue
4 and the challenge that it poses?

5 A. Sure. So, it's really - this is opinion rather than,
6 you know, substantiated fact: we have certainly seen a
7 rapid increase, probably 9 to 10 per cent a year, of
8 presentations to our emergency department of predominantly
9 teenagers with - that's an old-fashioned word - of
10 adolescents with depression, anxiety, self-harm,
11 difficulties with emotional regulation, conflict, sometimes
12 substance abuse and so forth. So, there's certainly been
13 an increase in presentation.

14
15 The problem that we have is that it's quite infrequent
16 that prevalence of mental disorders is assessed. The last
17 time in Australia it was 2014 and before that a long time
18 before, and the same in the UK, so we don't really have
19 very good epidemiological data to show that there's clearly
20 an increase in depression and anxiety in teenagers, but
21 there's certainly an increase in presentations.

22
23 And I think that there is a - there's certainly a
24 timing with the onset of the smartphone and the prevalence
25 of the internet and mobile internet in particular; it's
26 just really something that I guess I and others wonder
27 about. We're certainly all conscious of the risks and
28 benefits of having access to the internet for young people
29 and for adults as well.

30
31 There are certainly plenty of instances at a clinical
32 level, at an individual level, that I'm aware of that young
33 people have experienced, for example cyberbullying and have
34 had difficulties in relation to social media. So, I think
35 that it's part of the context but it might be that there's,
36 you know, a lot more to it than that.

37
38 Q. So that might be an area of further study in your
39 view?

40 A. I'd assume.

41
42 Q. Can I take you to another issue that you raised in
43 your statement which was about the fact that you said that
44 you were aware that there were paediatricians in parts of
45 Victoria who closed their books to children and adolescents
46 with mental illness. Can you just talk a little about
47 what's the implication of the closing of their books, what

1 happens as a result of that?
2 A. I mean, I think - you know, this is probably a sort of
3 a plea for the availability of mental health care where
4 young people, children and adolescents need it and when
5 they need it. I think it's important, as I said, no health
6 without mental health, and I think paediatricians, general
7 practitioners, we should all be seeing mental health as
8 part of health.

9

10 I think it's problematic, from where I sit anyway, to
11 have paediatric health providers who are able to see
12 certain sorts of conditions and not others, but I think,
13 you know, that's partly because they're predominantly
14 private practitioners, and so, I think if we had community
15 paediatricians who were, you know, salaried, then we might
16 find that we can be clearer about the sorts of range of
17 conditions that might be seen.

18

19 I do make reference in my statement to the
20 disincentives to treating mental illnesses in, for example,
21 a paediatric practice: the MBS items, the requirement
22 typically for the child to be in the room, but in fact many
23 of the interventions for children are best delivered in an
24 evidence-based fashion with parents, and the lack of
25 support that paediatricians in private practice, for
26 example, experience when they might have mental health -
27 young people with mental health difficulties.

28

29 Q. And then my final issue I wanted to ask you about was
30 in relation to telehealth and telepsychiatry. In your
31 statement you make the point that it's not widely used.
32 Can you talk a little: is there a reason why, or is it just
33 about the availability and familiarity of that as a new
34 medium from which to deliver?

35 A. Once again, I have to be clear, I don't have data on
36 the rates of telepsychiatry, but I'm not aware of a great
37 deal of it going on. It's perhaps symptomatic that there
38 may well be a great deal of telepsychiatry going on in
39 CAMHS and CYMHS services but, because there isn't a
40 collaboration between those CAMHS and CYMHS services, other
41 CAMHS and CYMHS services wouldn't be aware of that.

42

43 Telepsychiatry is really ideal for reach for regional
44 consumers who might have to travel a long way, but there's
45 also a lot of children who, for example - and we haven't
46 really talked about this group - children who might have
47 developmental disabilities who in fact coming to a clinic

1 or coming to a hospital is very difficult and in fact
2 distressing. So, the availability of mental health care,
3 which may not necessarily require the practitioner to be in
4 the room, into the home of children and families I think
5 would be an enormous advance.

6
7 CHAIR: Thank you very much.

8
9 MS COGHLAN: Thank you, Chair. May the doctor be excused,
10 please?

11
12 CHAIR: Yes.

13
14 **<THE WITNESS WITHDREW**

15
16 MS COGHLAN: Is now a convenient time to break for lunch?
17 The next witness will be called at 2 pm.

18
19 CHAIR: Yes, let's break for lunch.

20
21 **LUNCHEON ADJOURNMENT**

22
23 **UPON RESUMING AFTER LUNCH:**

24
25 MS NICHOLS: Commissioners, I call Professor Patrick
26 McGorry to give evidence.

27
28 **<PATRICK DENNISTON MCGORRY, sworn and examined: [2.01pm]**

29
30 MS NICHOLS: Q. Professor McGorry, have you, with the
31 assistance of the Royal Commission, prepared a statement
32 about the opinion you give in relation to the questions
33 we've asked you?

34 A. Yes.

35
36 Q. I tender the statement. [WIT.0001.0023.0001]
37 Professor McGorry, you probably won't need to, but if you
38 do need to refer to your statement when I'm asking you
39 questions, you may do so. Do you have a copy of it there?

40 A. I do, thank you.

41
42 Q. Are you the Professor of Youth Mental Health at the
43 University of Melbourne?

44 A. Yes.

45
46 Q. Are you the Executive Director of Orygen, The National
47 Centre of Excellence in Youth Mental Health?

1 A. Yes.

2

3 Q. Were you a Founding Director of the Board of the
4 National Youth Mental Health Foundation, otherwise known as
5 Headspace?

6 A. Yes.

7

8 Q. Are you a Fellow of the Australian Academy of Science
9 and the Australian Academy of Health and Medical Sciences?

10 A. Yes.

11

12 Q. Are you President of the International Association for
13 Youth Mental Health?

14 A. Yes.

15

16 Q. I won't ask you any more questions, but we have your
17 very long and impressive CV, thank you, Professor McGorry.

18 A. Thank you.

19

20 Q. Can I start by asking you about the notion of staged
21 care. In your statement provided to the Commission you've
22 said, "Mental health services need to provide staged care",
23 and you used the expression "Right care, right time, right
24 intensity."

25

26 Can you explained what you mean by "staged care" and
27 how, if at all, that's different from what is presently
28 embodied in Victoria's mental health system?

29 A. Yes, sure. Well, staged care - staging is a concept
30 which we've really borrowed from other areas of medicine;
31 probably most people are familiar with it in cancer but
32 it's used in many other potentially persistent or chronic
33 conditions, and it's a way of actually refining diagnosis
34 so that you deliver the appropriate type of care according
35 to the stage of illness that the person is at.

36

37 So, I'll just give an example. If someone presents
38 with breast cancer and it's in a very, very early stage,
39 you would not be doing radical surgery and intensive
40 chemotherapy and radiotherapy, which you would do if the
41 cancer had spread throughout the body and it was a more
42 serious situation.

43

44 So, in psychiatry we've tended to just ignore stage of
45 illness and just offer treatment, you know, to whatever the
46 label or diagnosis actually was, so this is a way of
47 refining treatment.

1
2 The other beauty of staging as an idea is that you try
3 to get ahead of the game. It's different from step care,
4 where you wait for treatment to fail and then you respond;
5 it's like playing catch-up. Staged care is where you
6 anticipate the problem may get worse, it may not get worse
7 of course, there's always - the great thing here is hope
8 and we're trying to maximise the chance of remission, cure
9 and recovery, those sorts of more ambitious goals, and that
10 means the treatment has to be a bit more proactive than you
11 would just expect, but not overtreatment.
12

13 So, at every stage of illness you have to balance the
14 risks and the benefits of treatment, and you can't expose
15 the patient to more risks than benefit, and that's the way
16 we've gone about our research, that's the way we've gone
17 about structuring the new types of clinical services that
18 we've actually developed.
19

20 Q. Yes, and when you talk about anticipation in that
21 context, does that imply that the person being treated has
22 a continuity of care and carers?

23 A. Absolutely. That would be the ideal situation, that
24 you would want to have continuity - hopefully the person
25 would go into remission and remain well at any stage, but
26 if they did progress or if they had an ongoing need for
27 monitoring and support and care, that that would be done
28 ideally with the same clinical team and the certain person,
29 because the relationship's so important, and certainly
30 within the same system as seamless as possible across the
31 different stages.
32

33 Q. In that model, is prevention described as stage 0?

34 A. I guess so. I mean, prevention can be - preventative
35 approaches can be delivered at almost any stage of illness,
36 but certainly the conventional view of prevention, as in
37 primary prevention or universal prevention, is stage 0 when
38 the person has no symptoms but might have a level of risk.
39

40 Q. Using the treatment of cancer as an analogy as you
41 have done, is it correct that a staged care model has these
42 features: first, the need to diagnose at the earliest signs
43 of potentially serious illness?

44 A. Yes.
45

46 Q. The need to get immediate access to care when there is
47 a diagnosis of serious illness?

1 A. Yes.

2

3 Q. And the need to sustain treatment efforts for as long
4 as necessary using the best available evidence?

5 A. Absolutely.

6

7 Q. And the need to keep people well or in remission and,
8 if the illness progresses, to limit its impact?

9 A. Yes.

10

11 Q. Alright. So, is it correct that a key goal of staged
12 care is to reduce the risks of progression from one stage
13 to the next?

14 A. Yes.

15

16 Q. I take it, you say that what we don't have embodied in
17 the mental health system in Victoria is a model of staged
18 care?

19 A. We don't have it, no, even though that there's really
20 good evidence from, I suppose, oases of programs, or
21 programs that have been set up that can show that it's
22 actually possible; it's absolutely possible in mental
23 health just as it is in other areas of health care, but it
24 hasn't been scaled up so as to make it possible for
25 everybody.

26

27 Q. Do you say that, in contrast to a model of staged
28 care, you have a model within which people are treated
29 within silos moving up to the next stage of care when their
30 condition has worsened?

31 A. Yes, and even then they cannot get access to care;
32 even when the condition has worsened considerably, that
33 people can still not get access to the next level of care.

34

35 Q. I want to turn your focus to young people, if we may.
36 Yesterday, Professor Helen Herrman gave some evidence that
37 the peak age of onset of depression, anxiety and psychosis
38 is between 15 and 25 years of age; I take it, you agree
39 with that evidence?

40 A. Not precisely, it probably is a little bit more
41 nuanced than that. I would say, you know, some disorders
42 have their onset in childhood. We heard from Dr Haslam
43 this morning about that, disorders like ADHD for example.
44 But then around puberty you see this rise in anxiety and
45 depression in early adolescence actually, and then perhaps
46 disorders like psychoses, bipolar disorder maybe towards
47 later adolescence, but by 25, 75 per cent of the major

1 disorders of adult life have emerged for the first time.

2
3 Q. I'm going to ask you some questions about young
4 people, and in terms of how they are addressed as a group
5 in your statement, what do you mean when you say young
6 people? What age range?

7 A. We're talking about puberty, around, say, 10-12, that
8 sort of period for the reasons I've just mentioned, and
9 probably around the age of 25, the mid-20s. But I agree
10 with Dr Haslam, that you want to have fairly flexible rules
11 about the bottom and the top end, but where I disagree is
12 that the age of 18 as a dividing line is, this is probably
13 the worst possible time to have a division in service
14 provision.

15
16 Q. Yes, I'll ask you some more questions about that
17 shortly. But first, can you tell the Commissioners what
18 are some of the key reasons why young people are
19 particularly vulnerable to and often seriously impacted by
20 the onset of mental illness?

21 A. Well, it's not possible to answer that question in an
22 absolutely definitive way.

23
24 Q. Of course not.

25 A. But the major thinking behind this is that, first of
26 all, as their physical development is dramatically changing
27 from puberty through to, let's say late teens, early 20s,
28 so is the brain; the brain is actually developing in a very
29 quiet but dramatic way during that period and that does not
30 complete until around the mid-20s, that process of brain
31 evolution.

32
33 Obviously, the social environment, the developmental
34 challenges that young people face, and I'm sure everyone in
35 the room can remember or relate to that; the challenging
36 developmental tasks you have to face when you are making a
37 transition from childhood to adulthood: identity, social
38 relationship, peer groups, vocational pathways, developing
39 a sense of independence from the family, all of those
40 things are very, very challenging for any person, and I
41 think probably the interaction of these forces actually
42 creates an increased risk for poor mental health at some
43 point, and we know that 50 per cent of these young people
44 do develop a period of poor mental health during that
45 transition.

46
47 Q. Can I just stop you there. When you say "50 per cent

1 of these young people", to which group are you referring?
2 A. At some point during, let's say the beginning of high
3 school and the age of 25-30, 50 per cent at least of young
4 people will meet the criteria for a diagnosable mental
5 disorder during that period, there have been a number of
6 longitudinal studies that have shown that.

7
8 Q. When you say "diagnosable mental disorder", just to be
9 clear, do you include the entire range of mental disorders
10 including the high prevalence mental disorders?

11 A. Yes, I do include them, although I really think that's
12 a very unfortunate term, "high prevalence disorders".
13

14 Q. I accept that. Can I ask you this: does the evidence
15 show that young people have difficulty help-seeking in
16 relation to getting help for mental illness?

17 A. They have had a difficulty help-seeking, but that's
18 partly due to, I suppose, characteristics within the young
19 person, but it's particularly due to the fact that there
20 isn't - or there hasn't been until recently - the kind of
21 place where they would feel comfortable in seeking help or
22 engaged in seeking help.
23

24 Q. Yes, I'll ask you about that in a moment. Do you know
25 how the rates of prevalence of mental illness in young
26 people compare with the rates at which they do access help?

27 A. Well, we have good information on that up to a
28 point in Australia because we have had national mental
29 health surveys, although we seem to think we only need them
30 every 10 or 15 years.
31

32 But the last one that looked at this, there was a
33 child and adolescent one which stopped at 18 recently which
34 was mentioned this morning, but the last major one which
35 covered the young adult period to show that the highest
36 prevalence across the whole life-span was in this 18-24 age
37 group where the prevalence was 26 per cent in any
38 given year, which is the highest across the life-span.
39

40 Q. So, if the highest prevalence is 26 per cent - sorry,
41 that's for seeking help, accessing help, sorry?

42 A. And of the proportion of that 26 per cent that sought
43 help, 13 per cent of the young men that had a mental
44 disorder back in 2007, and 31 per cent of the young women
45 who had a diagnosable disorder were able to access any kind
46 of help; and that included things like school counsellors
47 or GPs, it didn't even mention mental health professionals

1 particularly.

2

3 Q. How does that compare with the percentage in adults,
4 if you know?

5 A. Well, if you look at middle-aged people in the same
6 survey, the proportion able to access some kind of help was
7 about 45-50 per cent, so still seriously inadequate, but
8 much better than the prospects for the young people at that
9 time.

10

11 Q. Just back on the statistics relating to youth, did
12 those services include psycho-social support services or
13 did they include - yes, did they include psycho-social
14 support services?

15 A. Yes, they would have included all kinds of health
16 professionals really; wouldn't have to be mental health
17 professionals even.

18

19 Q. Do you know whether the rates at which young people
20 are accessing help are improving?

21 A. Well, we're not totally clear about that. The child
22 and adolescent survey showed there was some improvement in
23 the under 18 group, in about a seven-year period since that
24 previous survey, and we know from the Headspace evaluations
25 that there's been a very significant improvement in access
26 in relation to what Headspace provides, so there has been
27 some improvement, it's still not where we want to be, but
28 it's definitely a step forward.

29

30 Q. What in your experience are some of the factors that
31 contribute to young people's disengagement with the mental
32 health system?

33 A. If we're looking at the whole mental health system --

34

35 Q. Yes.

36 A. -- there just isn't a mental health system beyond the
37 primary care level for the vast majority of young people.
38 There was extensive discussion this morning about the
39 missing middle; well, that's a very significant number of
40 young people and it's only a very tiny percentage that
41 actually get to the more tertiary end of the system.

42

43 Q. Is there a question about stigmatisation that's
44 relevant to that?

45 A. I think stigma is actually on the decline, actually,
46 especially in young people. If you talk to young people
47 these days - and I know the Commission has heard from young

1 people - stigma is a much less serious issue amongst young
2 people these days. It's still not beaten, it still exists
3 and it probably exists for some disorders much more
4 strongly than others, but young people are much more open
5 and, you know, I think less affected by it, even in the
6 last ten years, so there's been some great improvements in
7 that. Where there hasn't been improvement is the response
8 when they go actually seeking help.

9
10 Q. I see, so they're more willing to seek help?

11 A. Yep.

12
13 Q. But no more likely to get it; is that right?

14 A. They're somewhat more likely to get it but only at a
15 very mild level, as I say, and beyond that if it's a more
16 complex problem that needs longer term or more intensive or
17 specialised care, that's where the big problems are now.

18
19 Q. Do young people from culturally and linguistically
20 diverse backgrounds have other threshold problems that they
21 encounter in seeking and obtaining help?

22 A. Yeah, I think if you look at the Headspace data, it's
23 very strong in providing access for indigenous and for
24 LGBTIQ populations, extremely trusted, and access and
25 engagement is good there. From CALD communities less so,
26 so that's another sort of area where Headspace and that
27 primary care level needs to be strengthened and do a lot
28 better.

29
30 Q. Can I ask you about the inter-relationship between
31 paediatric services, youth services, to the extent they
32 exist and adult mental health services. Firstly, if you
33 can firstly generalise across different services, what are
34 the cut-off points for access to paediatric mental health
35 services?

36 A. Well, if you just look - take a step back a bit and
37 look at the history of how these services have developed.
38 Child psychiatry is quite a recent development within the
39 mental health field and it's struggled around the world to
40 actually get much traction. In many countries it doesn't
41 even cover the full range, even up to 18.

42
43 So, the conventional boundaries are 0-18, and then we
44 have 18 or 16-65 as the adult system. And I think this has
45 been adopted without any thought; it's just been
46 transplanted from the general medical system, where the
47 pattern of morbidity is very different from what you see in

1 mental health, and it's been assumed that's going to work
2 just as well for mental health. Whereas, in the mental
3 health area, the pattern of onset of disorder is the mirror
4 image of what you see in physical medicine.

5
6 Q. Can you elaborate on that, please?

7 A. Yeah. So, if you look at the pattern of Global Burden
8 of Disease data, there's a lot of serious physical
9 illnesses in little kids, in kids under 12, maybe even up
10 to the early teens.

11
12 And then, from the teenage years through young
13 adulthood and even into middle age, people have never been
14 healthier in human history, you know, from a physical point
15 of view, so the health system isn't really needing to be
16 strong from a physical health point of view in that space.

17
18 But in terms of mental health you see this surge of
19 morbidity, particularly from puberty through to the early
20 20s, of mental ill-health with a whole lot of comorbidity
21 amassing around it, and the system is incredibly weak, it's
22 weakest where it needs to be strongest.

23
24 And, if you have a paediatric adult model, if the
25 paediatric model peters out in the late teens and then the
26 adult system - medical system sort of kicks in around 50 or
27 something, so it's just - it's the wrong way of designing
28 it. No thought was given to that when we mainstreamed
29 mental health care into the physical health system.

30
31 Q. So, in mainstreaming, do you have this phenomenon
32 where a child or paediatric services is sort of reaching up
33 to encompass youth, and adult services are reaching down?

34 A. Yeah, well, people have tried to tackle this in either
35 of those two ways, and in a way it doesn't matter as long
36 as you have a system that's able to cover that, that sort
37 of transitional zone.

38
39 In Europe they call it transition psychiatry, this
40 12-25 sort of focus. We call it youth psychiatry in
41 Australia, and our college has got a section of youth
42 psychiatry now and thinking about having a faculty of youth
43 psychiatry, so I think there's been two approaches.

44
45 In Victoria about ten years ago there was a notional
46 effort to create a 0-25 service which you've heard about
47 this morning but it wasn't resourced, so didn't actually

1 function as a 0-25 service.

2

3 And, you know, there were supposed to be two zones, a
4 0-12 and a 12-25 zone, but that never really happened I
5 don't think.

6

7 Q. Can you say something about the ways in which access
8 criteria to adult mental health services either fit or
9 don't fit the needs of young people seeking access to those
10 services?

11 A. Well, again, you have to look at this historically.
12 You had the child psychiatry system coming out of the child
13 guidance clinics which were really about younger children,
14 and they gradually tried to move into the adolescent space,
15 but with a kind of a family approach, with a developmental
16 approach, which was very appropriate actually.

17

18 Then you had an adult system which was created out of
19 the old asylum system, which I trained in, I trained in
20 that system, which was totally focused on people with
21 chronic, severe mental illness, mostly schizophrenia and
22 related sort of conditions. And the adult system was moved
23 out of that system about 25 years ago and dumped into the
24 acute general system without really any evolution since,
25 except decline, and that was looking after a completely
26 different clientele.

27

28 And so, if you had an early stage illness of an adult
29 type, or if you were a graduate of Child and Adolescent
30 Service into the adult, it was like oil and water, not
31 mixing. And, there are studies from Europe and the UK
32 showing that the transition of patients from one system to
33 the other nearly always failed. In 95 per cent of cases
34 the transition would fail because the clientele were
35 different. And, if they did get in they wished they didn't
36 get in because it was not a present experience.

37

38 Q. You were speaking in the past tense. Is that
39 deliberate?

40 A. No, I think that's actually still the case, sadly.

41

42 Q. Still the case, and what do you say about the
43 discontinuity between the services occurring at the age of
44 16-18?

45 A. It's lethal.

46

47 Q. What do you mean by that?

1 A. Well, people have died because of this.

2

3 Q. I'm not going to ask you about individual cases, but
4 from a systematic perspective, what do you say about it?

5 A. Well, it's a massive design flaw.

6

7 Q. What's flawed about it, I'd just like to tease this
8 out a little bit if, I may?

9 A. What's caused the design flaw?

10

11 Q. What's flawed about it?

12 A. Oh, flawed, sorry. Well, it just doesn't work.

13 Access - first of all, the scale of the systems are not to
14 scale, but you've got to focus on the needs of the client
15 group, and there's been no thought to that actually, in the
16 design of that part of the system.

17

18 Now, the needs of the people in middle age in the main
19 adult system, that's different, you have to design that
20 part of the system for the needs of those patients, some of
21 whom are new patients too.

22

23 But in this transitional zone, you know, we put a lot
24 of effort in research and other ways into actually mapping
25 what the needs of the patients actually are in that stage,
26 including involving them in this process, and it's very
27 clear, you need a culture of care and a range of expertise
28 that is relevant to the needs of the people trying to use
29 the system.

30

31 We've also tried to link it, as I think Dr Haslam said
32 this morning, to primary care because of the volume of
33 cases needed. We were operating services in the
34 northwestern Melbourne about 20 years ago and we were
35 trying to create a youth mental health service then. We
36 realised we were treating 800 patients a year, and there
37 were 50,000 patients in that catchment area who needed some
38 kind of mental health response.

39

40 So, you have to have a high volume system that is
41 capable of actually responding to the very large prevalence
42 and the incidence, and then a system that's able to then
43 take them through more intensive steps of care or stages of
44 care according to their needs, and that was never done.
45 It's kind of - the system has evolved from these historical
46 origins without anyone really designing it according to its
47 needs.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. What you're speaking about is an instance of the philosophy of person-centred design; is that right?

A. Absolutely.

Q. One of the things you mentioned earlier was what happens with young people is an important blend of comorbidities of variable intensity, including substance abuse issues. Is that important?

A. It is. Because we've learned a lot in the last 15 years or so by working right from the beginning of these illnesses and problems, and obviously a lot of young people get better and they recover, but the people who come in for the first time with the need for care, they often have what we call micro phenotypes, meaning they've got fragments of symptoms: some anxiety, some depression which fluctuate. They might then self-medicate in different ways or self-harm, but it's not clear what's actually happening and it's not a stable picture.

And the picture, it might actually fade and they might recover, or they progress and then they might develop other features; you know, perhaps eating disorders, perhaps psychotic symptoms, and their personality development is affected too, so they get labelled with a personality disorder diagnosis then too, so their complexity increases if they don't get better, and their needs increase and the skill level to actually get them better then increases too.

Q. Can I ask you now about early intervention more generally. In professional and academic discourse, how is that expression defined?

A. Well, I think our local Health Department confused everyone by using it in several different ways: you know, this early in episode, early in life and early in illness type; but in the research and the professional literature we define it - and I did a journal called Early Intervention Psychiatry - we define it as early in the illness course, that's what we mean it to be.

Q. So, does that mean intervention once the signs of an illness have first emerged?

A. Yeah. So, again, going back to the staging model, the earliest clinical stage, and there's been obviously debate about this in the general public and the media: what is the earliest point at which you can say someone needs care? And it doesn't necessarily align with classic DSM and other

1 diagnoses. It's when there's a level of distress that
2 prompts help-seeking in a person, and often that's
3 associated with functional impairment but not always, but
4 that actually ought to be left up to the patient.

5
6 No-one tells you in physical medicine that you can't
7 go and see the GP; no-one says you're wasting everyone's
8 time by going to the GP. If you feel unwell, if you've got
9 a sore throat and it's not getting better, or if you've got
10 a stomach upset, no-one says, "Sorry, you can't see the GP
11 until it gets worse." But that's what we've tended to do
12 in psychiatry. We've tried to say somehow that's harmful
13 to people to seek help at those earlier stages because they
14 might get labelled, they might get stigmatised.

15
16 But that's not the case actually. Because in primary
17 care settings we can actually create settings that are very
18 stigma free, and they can actually get the appropriate help
19 without having to be put into a hard label or a diagnosis
20 that's going to stick with them, they can just get help.

21
22 Q. Just while we're on that topic, you mentioned before
23 that you thought stigma was declining amongst young people;
24 is that a reflection of the experience you've had in the
25 settings in which you work, which affirmatively works to
26 reduce stigmatising factors?

27 A. I think it's both actually. I think the young people
28 themselves have actually been very good, they've actually
29 helped to destigmatise in a great way. So, that's
30 happening independently to some extent, but we've
31 definitely worked really hard with them to create settings
32 where stigma is just not an issue.

33
34 Q. In relation to early diagnosis and prevention in fact,
35 you have drawn an analogy in your statement with cancer
36 prevention and cancer treatment. Can you explain that
37 analogy and why you think it's instructive?

38 A. Yeah, some people might think cancer is, like, too -
39 what's the word - deterministic. So, I could say that it
40 also applies to other areas too.

41
42 Q. Or whatever it is that you think, yep.

43 A. But what (indistinct) medicine say. I just think it's
44 very interesting because in those areas they have actually
45 reduced the burden of disease. In cancer they - you've got
46 much better prospects of survival in many cancer areas and
47 if you don't - if the cancer's not cured you can live for

1 longer, so they've done so many things right: they've done
2 prevention where they can, and we can do a lot more in
3 prevention in mental health, so reduce the risk in some
4 areas.

5
6 They diagnose it early, as early as possible, and then
7 if they get the person well, into remission, they do
8 everything they can to keep that person well. And even if
9 the person has this more recurrent and deteriorating
10 illness, they actually provide much better palliative care
11 too. So, all of those things have helped greatly and, as a
12 former Director of NIMH, Tom Insel, used to say, they bent
13 the curve, they bent the curve of morbidity and mortality
14 and we haven't been able to do that in mental illness.
15 It's not because we don't have the interventions or the
16 evidence-based treatments or the capacity to do it, but we
17 just have not implemented it, we have not actually built a
18 system that delivers what we already know effectively.

19
20 I could give about ten different examples of
21 treatments that I've seen developed in my time in
22 psychiatry, new treatments, drug therapies and also
23 psycho-social treatments, including many that we've
24 developed here in Victoria, that are simply not available
25 to people; they're not what the system delivers. The
26 system delivers this very basic generic case management and
27 risk management system; it doesn't deliver all the things
28 that we already have at our disposal in an effective way.

29
30 If we did those things and if we did them according to
31 that framework I just mentioned with cardiovascular and
32 cancer with, you know, those four elements, we would
33 transform the outcomes for people with mental illness even
34 without a single new discovery.

35
36 Q. Later on I'm going to ask you why you think we don't
37 do that, but before we go there, I'm going to ask you a
38 little bit more about early intervention. It's comprised
39 of two parts, you say; the first being early detection.
40 From a systems perspective, how do you think we can achieve
41 early detection better?

42 A. Well, a lot of the evidence for this conference about
43 those statements comes from the period in which we were
44 developing early intervention for psychosis, for psychotic
45 disorders like schizophrenia, which was the precursor to
46 our broader work transdiagnostically in youth mental
47 health.

1
2 I'm thinking in particular of the work of a group in
3 Norway who carried out the TIPS study. One of the big
4 problems with schizophrenia and psychosis was that it was
5 being diagnosed very late, often after years of illness,
6 certainly on average after about a year or two of psychotic
7 symptoms when the person's life was absolutely in ruins by
8 the time they actually got the first help.

9
10 As you would imagine with any potentially serious
11 illness, that makes it very, very difficult to achieve
12 recovery if the person's that unwell. So, shortening the
13 clay in treatment was a crucial strategy.

14
15 They showed that, by very widespread community
16 education, spending a lot of money on educating the public
17 about recognition of the early signs of psychosis, and the
18 leader of that study used the analogy with a local
19 supermarket which he said spent more on advertising
20 Coca-Cola than mental health services spent on advertising
21 their services. So, doing that, so very sophisticated
22 public advertising campaign.

23
24 Q. Can I just stop you there. If you know, what were the
25 elements of the very sophisticated public campaign?

26 A. Okay. So, it was cinema ads, this is the 90s, so you
27 know could be different these days. But cinema ads,
28 newspaper advertisements, public hoardings, bus shelters
29 covered with information about psychosis, information in
30 schools, lots of ways of educating the public about how to
31 recognise the early signs of psychotic illness.

32
33 And that, combined with a telephone number that they
34 could call and a team would go out and see that young
35 person wherever they were, whether it was in the school,
36 the primary care setting, the home. So, the team would
37 respond immediately to a referral where there was a
38 suspicion that psychosis might be present.

39
40 Q. So you needed both things?

41 A. You needed both things.

42
43 Q. Or they established you needed both awareness and
44 someone to respond when people took steps to seek help?

45 A. Yes, and they did very skilled research which showed
46 that both of those elements were necessary, and they showed
47 that you could reduce the delay in treatment from two years

1 down to a matter of a few weeks.

2

3 Q. This was Scandinavian; in which country?

4 A. Norway.

5

6 Q. And it was the TIPS study, did you say?

7 A. The TIPS study.

8

9 Q. You said in your statement that early intervention
10 includes first early detection, and second, staged-linked
11 multidisciplinary clinical care to cover the years of
12 illness post-diagnosis. Now, you may have covered some of
13 this already, but can you just tell the Commissioners in
14 your view what are the key points or what are the key
15 attributes of multidisciplinary clinical care?

16 A. So, when we first started doing this work, what would
17 happen to a first episode patient with psychosis would be,
18 they would come in late in the piece, they'd be patched up
19 and sent back out again after probably just a few weeks of
20 treatment and hoping that the person would be okay,
21 probably the GP or maybe a community clinic would be
22 looking after them.

23

24 But the second component in terms of changing the
25 outcome was much more extended and much more intensive and
26 comprehensive multimodal clinical care to maximise the
27 level of recovery and then make sure the person remained
28 well at least for the first couple of years after
29 diagnosis.

30

31 Q. What do you mean by multimodal in that context?

32 A. Well, much more careful use of medication, because
33 patients were being overmedicated in those days. So, low
34 dose medication but carefully - and, if they weren't
35 getting better, early use of clozapine as a drug therapy.

36

37 And then a whole range of psycho-social treatments
38 which were actually developed, you know, many of them here
39 in Victoria but some in other parts of the world to be
40 offered to - so, things like family intervention,
41 vocational recovery programs, CBT, a range of strategies
42 like that to help the person make a more complete recovery.

43

44 Q. Yes. And, is the length of time over which treatments
45 and services are provided particularly important?

46 A. Well, it was called "the critical period" by early
47 psychosis researchers, especially like Max Birchwood.

1 Initially we thought it was about two years, but further
2 research has shown that it's actually the first five years
3 of illness that's important. And, after that, there's a
4 tendency for things to get significantly better, you know,
5 in a more naturalistic way actually, that's what we're
6 seeing. So I think we can shrink the proportion of
7 patients that actually end up with a more chronic and
8 severe outcome; the research is really pointing us strongly
9 in that direction now.

10
11 Q. Do you think that there is an indication that the
12 research in the area of psychosis is potentially
13 generalisable to - or applicable to other disorders?

14 A. Well, that's what we've been trying to do, I would
15 say, for the last 15 years or so. Expand the thinking of
16 early intervention so it includes all the potentially
17 serious mental disorders of adult life: mood disorders,
18 eating disorders, personality disorders, substance use
19 disorders. Of course, they often tend to be mixed up
20 together, so that's the proposition, and we are getting
21 some increasing data showing that is likely to be the case.
22

23 But the fact that we could do it for the most serious
24 form of mental disorder in this age group, schizophrenia
25 and psychosis, is very encouraging for the prospects for
26 other disorders too.
27

28 Q. Can I ask you some questions about what we know about
29 what early intervention is capable of achieving. It's
30 right, isn't it, that early intervention isn't always
31 capable of preventing development of a mental health
32 condition?

33 A. Yes, that's absolutely true.
34

35 Q. In the evaluation of the work that you've been doing,
36 there were a couple of conclusions that you discuss in your
37 statement. The first type is the capacity to delay the
38 first onset of illness where there are warning signs, and
39 the second is the ability to improve outcomes over the
40 first two years where there is in fact a first episode of
41 psychosis. Is that right?

42 A. Yes. For those two statements there is now what we
43 call Cochrane level one evidence, meaning the top level of
44 scientific evidence suggesting that that should be
45 available to everybody.
46

47 So, Alison Yung and I back in the early 90s,

1 operational as the criteria for what we called the at risk
2 mental state or the clinical high risk state for psychosis,
3 and these were subthreshold psychotic symptoms, so warning
4 signs of fully-fledged psychosis. What we have now is
5 probably about 15 or 16 randomised clinical trials showing
6 that the transition from that state into first episode of
7 psychosis can be delayed by at least one year, maybe two
8 years, maybe even longer.

9
10 It doesn't mean that we're necessarily able to cure
11 the illness, but we can certainly delay the onset, which it
12 should be something that we are celebrating all over the
13 world because, if that's possible in diabetes - there was a
14 paper just recently saying that they think they can delay
15 the onset of diabetes, and that attracted a lot of
16 attention. We can do that already with schizophrenia and
17 psychosis.

18
19 Q. Would you accept that, starting with the proposition
20 that psychotic illness is an umbrella term of which
21 schizophrenia is one type, would you accept that in the
22 literature and in the scientific community there is a
23 debate about the conclusions in relation to schizophrenia
24 in particular?

25 A. The debate was more about whether we would do more
26 harm than good trying to intervene at that stage of
27 illness, and I think the debate strayed a long way from the
28 data, is my perspective on it. The data is absolutely
29 clear. As I say we have these metaanalyses now that show -
30 the facts show that it's possible to do that. We've done a
31 lot of rigorous research.

32
33 We've done five of these trials here in Melbourne and
34 the latest one funded by the National Institute of Mental
35 Health in Washington has just been completed now. So,
36 there's a lot of experience and data. You can have debates
37 about things but then there are facts.

38
39 Q. Can I ask you this: in terms of the importance of
40 early intervention from a systems perspective in your
41 opinion, is it a very important investment notwithstanding
42 that not every instance of psychotic illness or other
43 mental illness will be able to be prevented?

44 A. M'mm.

45
46 Q. You talk about some evaluations that have been done of
47 the work at Headspace and you say this in your statement,

1 that:

2

3 "Outcomes are modestly improved for mild to
4 moderately ill young people and access is
5 greatly enhanced, as is satisfaction with
6 the care received."
7

7

8 Can I just tease out the elements in that statement?

9

A. Sure.

10

11 Q. The first one is, "Outcomes are modestly improved for
12 mild to moderately ill young people". Can you explain what
13 you mean by that, both in relation to outcomes being
14 modestly improved and mild to moderately ill young people?

15

A. Sure. So, could I just make it clear that we've now
16 moved off the topic of early psychosis and we're moving to
17 more generally transdiagnostic patients?

18

19 Q. We are, sorry, I should have made that clear.

20

A. No, that's fine. Can I just say one more thing about
21 psychosis before I answer that?

22

23 Q. Sure.

24

A. So the second part of your earlier question was about
25 people who then have established psychosis and trying to
26 improve the outcome over the first couple of years for
27 those patients. That's another meta-analysis that was
28 published last year in JAMA Psychiatry by Christoph Correll
29 and colleagues, and that looked at 10 RCTs of first episode
30 psychosis care which showed, again, that the outcomes were
31 substantially better on about ten different outcome
32 measures for the first two years, and that has led to the
33 US Congress signing funding for these programs to be rolled
34 out across the US. So, they are now in 280 settings across
35 the US. So, that second staged care is now highly
36 evidence-based and being implemented in a very widespread
37 way.

38

39 Q. Thank you. Alright, let's return to --

40

A. Headspace.

41

42 Q. -- the more general proposition about the outcomes
43 across the board and the statement that "outcomes are
44 modestly improved for mild to moderately ill young people".

45

46 We'll come to access in a minute but can you just
47 explain what is meant by that statement?

1
2 A. So the government has done two evaluations
3 independently of Headspace since it was commenced in 2005.
4 The first one was very early on and descriptive. The
5 second one looked more at what outcome data was available,
6 and you have to understand these Federal Government
7 evaluations are done with very little funding actually,
8 they're not proper health services research studies. So,
9 the people at the University of New South Wales who did
10 this evaluation, did the best they could with the data they
11 had.

12
13 What they concluded was that, in terms of outcome,
14 about 60 per cent of the patients that came to Headspace
15 were helped significantly by it compared to standard care.
16 It's very hard to find a comparison group of standard care
17 for these patients because hardly any of those patients
18 were treated in standard care before, so that's like a
19 caveat there.

20
21 But as best as they could determine, about 60 per cent
22 were doing well as a result or better because of the
23 interventions compared to what they would have had in
24 different forms of care.

25
26 Another 40 per cent were either treading water or
27 deteriorating. And, you know, Headspace being a primary
28 care service is not capable of helping people who have got
29 more moderate-to-severe conditions, and yet, there's
30 nowhere else for them to go in most parts of Australia.
31 Very few of them would make it into specialist services, so
32 we think that that 40 per cent are the ones that are not
33 doing well and that's why we need this next tier of care.

34
35 Q. You also say that "access is greatly enhanced", and by
36 that do you mean that a great deal many more people get
37 access to help of any kind?

38 A. That's what the University of New South Wales group
39 concluded, that access was dramatically improved, and also
40 the satisfaction levels and the engagement levels of the
41 young people with the services was greatly improved as
42 well, and that's what we find. Because the youth
43 participation, youth engagement model within Headspace has
44 created a youth-friendly culture which young people can
45 engage with.

46
47 Q. You mentioned the concerns about over-medicalisation a

1 few moments ago. Would you agree that, in a clinical
2 staging model properly designed, that the overtreatment and
3 premature use of medications is guarded against?

4 A. Well, that's the whole purpose of it actually, to make
5 sure you don't undertreat or overtreat patients. You make
6 the treatment of the person proportional to the stage of
7 illness that they're at.

8
9 When I first started in psychiatry, I saw massive
10 over-treatment of people who basically were at an early
11 stage of illness and they were being treated as if they had
12 stage 4 illness essentially and they were getting huge
13 amounts of medication and nothing else really, so
14 absolutely the staging model guards against that as its
15 purpose.

16
17 The other thing that guards against it I think in the
18 Headspace setting is that, we try to make these settings
19 not overtly clinical; they should have a youth café feel
20 almost at the entry point but with the clinical expertise
21 sitting within the system so that it's available but it's
22 not thrust in the face of the young person.

23
24 And also make sure that the psycho-social treatments
25 are offered as the first step and not overtreatment with
26 medication at the first step.

27
28 Q. Yes, I was going to ask you about this and I want to
29 ask your opinion more generally, not confined to the
30 Headspace model, but what do you say, on the basis of your
31 experience, is the importance of psycho-social treatments
32 and programs in dealing with mental illness?

33 A. Well, since the beginning of my career I've put a lot
34 of my own research effort into the development of
35 psycho-social treatments, and so, I think it's very, very
36 important.

37
38 I was struck back in those days at a lack of
39 sophistication and the lack of evidence-based treatment of
40 that kind: whether they were psychological or more, I
41 suppose, social forms of treatment.

42
43 I think the situation's been greatly improved since
44 those days, with the advent of forms of CBT that are
45 tailored for different types of problems, even for
46 psychotic illnesses now, from vocational interventions like
47 the Individual Placement and Support Model which

1 dramatically improves the prospects for people with mental
2 illness to get back into education and into employment.
3 Those are just some examples.
4

5 And I suppose, we could do more. I mean we have now
6 virtual reality which can actually add a lot of potency and
7 attractiveness to the psychosocial treatments or the
8 psychological treatments.
9

10 Q. Can you say a few words about virtual reality, what
11 you know about it, the extent to which it's been
12 implemented and what kind of promise it shows?

13 A. Yeah. It's already being offered and it's more
14 developed in Europe and the UK for a range of conditions.
15 We have facilities in Melbourne now where we're getting it
16 off the ground as well but probably a little bit slow to
17 embrace it actually.
18

19 But the sort of conditions that it would be used for
20 would be PTSD, would be anxiety, it can also be used in
21 psychotic illnesses to in vivo, in real life almost, deal
22 with paranoia and actually help people in a cognitive sense
23 deal with paranoid thinking and experiences, so it's got a
24 huge amount of potential to transform the office spaced
25 therapies that we currently do, which are pretty boring a
26 lot of the time for patients, to actually make it a lot
27 more real and a lot more effective.
28

29 Q. Is it fair to say that the work with virtual reality
30 is currently in experimental stages, at least in Australia?

31 A. Yeah, I think that's fair to say. It's a research
32 technique now which, that's what we do at Orygen, we try to
33 bring these research techniques into the real world. But
34 in countries like the Netherlands and the UK, they're
35 already doing that.
36

37 Q. Is the use of virtual reality an example of
38 application, mostly of cognitive behavioural therapy?

39 A. Yeah, I think that's fair to say at the moment,
40 although there might be other more creative ways to use it
41 as well.
42

43 Q. Can we switch topics, Professor McGorry. I'm going to
44 ask you about the group of people who you have called "the
45 missing middle". In the context of mental health, who are
46 they?

47 A. We've already touched on it, but these are the people

1 who have needs beyond what the primary care system - so
2 your standard GP/Better Access or Headspace - can provide.
3 And yet, they cannot reach the very high bar that has to be
4 reached for access to State Government funded tertiary
5 services.

6
7 You could divide them up into two groups. You could
8 say, it's a significant proportion of the moderately ill,
9 mentally ill group, and it's even a proportion of the
10 severely mentally ill group which the state service are not
11 currently covering. In my statement I put percentages on
12 that, so it's probably between 8 and 10 per cent of the
13 public.

14
15 Q. Have you done the numbers on what that means?

16 A. Yes.

17 Q. How many thousands of people?

18 A. I think it's about 300,000 in Victoria, around about
19 that number.

20
21 Q. Are, what, missing out on services altogether?

22 A. Yeah. So, if you think about 20 per cent of the
23 Victorian population roughly needing some kind of mental
24 health care, that's about 1.5 million, in my rough
25 calculation, and so the missing middle, if it's about
26 6-8 per cent, that sort of ballpark, it's a few hundred
27 thousand. And when you look at the number of people who
28 are getting services in Victoria for mental health, it's a
29 hell of a long way short of that.

30
31 Q. Yes, and what kinds of services are available to the
32 people who fall within that group?

33 A. Well, some of those people - and I'm sure the figures
34 could be assembled on this - would have access to private
35 psychiatrists. But, as we all know, there's very
36 significant financial barriers and geographic barriers to
37 accessing those services, and in my view those services are
38 very poorly designed as well: they're single office-based
39 practitioners, they're highly trained, but they are not
40 working in teams by and large, and so they're not really
41 meeting the needs of these patients as well as they could.

42
43 But there would be a percentage of the missing middle
44 that are accessing those services, but I guess we see and
45 hear about all the people that cannot do that, especially
46 in public mental health care.

47

1 Q. Does access to the mental health care system often
2 only occur when those people find themselves in real
3 crisis?

4 A. Or dead. I mean, these people can only get access
5 when it's a life-threatening situation, and that's the way
6 it seems; or when they're causing so much disturbance
7 because of their illness that they end up being brought to
8 an emergency department, or worse still, into police
9 custody and in prison.

10

11 Q. You've talked in your statement about what you call a
12 community-based model of care that links to primary care
13 and provides access to services for more complex cases and
14 allowing upstream access to emergency departments. What
15 you've said is that:

16

17 "Structures like this, if funded to operate
18 around the clock, could dramatically reduce
19 the flow of acutely mentally ill patients
20 into emergency departments and reduce
21 attempted and completed suicide
22 substantially."

23

24 I'd like you to say some words about this model,
25 recognising that it's a model rather than an embodied
26 reality at the moment. You have kindly answered my request
27 to create a diagram representing it. Can I have that
28 diagram shown, please?

29

30 There are a lot of elements in here, and can you first
31 step us through, without going into detail, the four
32 different parts on the four corners of the diagram?

33

34 A. Sure. I mean, could I just first say that, I think
35 when the system in the 1990s was designed to replace the
36 old asylum system, that was the intention, to actually set
37 up strong proactive community mental health services that
38 would allow us to cope with a dramatic reduction in acute
39 beds. And that did start to work at first, because those
40 services did do those things up to a point; the CAT teams
41 did actually turn up, the CAT teams did actually visit
42 people even up to two or three times a day to keep them
43 well in the home, and that started off on the right foot, I
44 would say.

44

45 So this is just more like a 20 year later version of
46 what we should design with the benefit of hindsight over
47 the last 20-odd years.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. Yes, understood.

A. A couple of things to say about it - very, very important. We assumed at that time it was a good idea to link the community mental health services with the acute hospital and put it onto the governance of the acute hospital. Because it made sense that you want to have continuity of care across, you know, inpatient and community.

But the trouble is, that was a big anomaly for the hospital systems. The hospital systems otherwise did none of that, they just did inpatients' work, so the idea of looking after services in the community wasn't really something that they ever really embraced, and so, that was a fundamental flaw in my view. Now, maybe not everyone agrees with that, but that's certainly my very clear view now.

So, how we finance and govern these systems is absolutely crucial to allow them to sort of meet scale and to operate.

Q. I'm going to ask you some questions a bit later about all of those really big points, including governance, but let's just have a look at your model. [RES.0001.0009.0681]

A. Focus on this model.

Q. I note that the four quadrants are divided by reference to age.

A. Yes.

Q. Over in the top right-hand quadrant there's - I don't know what to call it, I don't want to call it a silo, I think that would be a mistake, but there's a section for 0-11 years.

A. Okay, so this is meant to be what a region, you know, would need. There may be other elements that a whole city like Melbourne might still need which I haven't put in there, like for example beds for younger children, inpatient beds. But let's say a modestly sized region of Melbourne could support this type of structure.

I probably shouldn't start off talking about the inpatient bit first because it's the least important bit numerically, but you need several types of inpatient facilities in such a region. We believe that the youth

1 beds should be separate from the adult beds, and you
2 probably need several types of adult beds. You need a
3 standard sort of psychiatric acute inpatient unit. You
4 obviously need a secure one too because there's a small
5 group of patients who are extremely aggressive and violent
6 by the time they become ill at this stage and you don't
7 want those patients being looked after in the same setting
8 as a more therapeutic sort of inpatient unit of the more
9 general type.

10
11 Q. And those are the ones listed in the centre of the
12 diagram, is that right?

13 A. Yes. And then there are youth versions of those, a
14 mother and baby at the top there, and also addiction units
15 for detoxification in a highly supervised medical way,
16 which we've moved away from that in some ways. These are
17 life-threatening conditions these phases of detoxification
18 so you want to have addiction specialists in charge of
19 those units, not lay people. So, that's another element of
20 the whole thing.

21
22 How those units relate to the psychiatric units
23 obviously needs more thinking, because there's so much
24 comorbidity as well. So, those are basically the notional
25 elements of that part.

26
27 Outside of that, rather than having an emergency
28 department that, where psychiatric and acute medical
29 patients are triaged in the same way, I think there's a
30 strong feeling that we should have separate spaces that
31 have got a completely different ambience and a completely
32 different skill set and time course. Not, you know,
33 short-term admission stays either, we're talking about more
34 a lounge or a café style place which is calming but still
35 got the capacity with expertise to respond to, you know,
36 very unstable situations as well. That also would need a
37 lot of design and thinking to actually set that up in a
38 safe and effective way.

39
40 So moving back out into the community, and we then
41 probably need several types of missing middle type services
42 which are these community hubs or one stop shops that have
43 been described here. And they're designed according to
44 stages of life, if you want to call it that. You need
45 different cultures of care, we think, for younger children,
46 so up to 11; it has to be a very different sort of type of
47 environment for kids of that age.

1
2 And also, the professionals that are needed to work in
3 that sort of setting are different types of people from the
4 sort of people that want to work with the adolescents and
5 emerging adults on the one hand and the middle-aged adults
6 on the other. So, that's the case we're making, that you
7 need these highly specialised, dynamic places which should
8 operate around the clock. They should have the capacity to
9 actually do outreach work around the clock, home-based
10 treatment around the clock, not just up until 11 clock at
11 night.

12
13 And they should have expertise during the day and
14 during extended hours in a range of domains which are
15 listed there, things like physical medicine, addiction,
16 different mental health professional disciplines there,
17 obviously psychiatrists as well; the evidence-based
18 treatments that we have for that more specialised stage of
19 illness. And we think that they should be embedded much
20 more with primary care than with hospitals. That's what
21 the World Health Organisation says about mental health
22 care, it should be very nested with primary care, not so
23 much with institutions and hospitals.

24
25 Q. While you're there, if we take the 0-11 years as an
26 example, there are links going out to primary schools,
27 early childhood centres and maternal health and childhood
28 centres, among others. So, is the linkage in that pretty
29 important?

30 A. Yeah, well, that's really the concept of primary care,
31 you could say, and community for those more specialised
32 services. That's where they have - they have to provide a
33 back-up for those services and a portal, and that will also
34 make them much less stigmatised than if they were
35 associated with more traditional psychiatric-type clinics
36 which are very narrow. This is a holistic model that we're
37 talking about here, not just purely psychiatrically or
38 mental health driven. And physical health is obviously a
39 key part of it, and GPs in particular are important there.

40
41 Q. Could I ask you a couple of questions about the model.
42 You have a grouping on the upper left-hand quadrant of
43 12-25 years. What do you say about grouping that age group
44 all together and the risk that those in the earlier part of
45 that age group will miss out and not receive sufficient
46 attention?

47 A. Well, I heard Dr Haslam talking about that this

1 morning. I think that's an issue for inpatient care; you
2 have to create zones in inpatient care where, you know,
3 that spectrum of age is handled in slightly different ways.
4

5 But we have, you know, over 12 years of experience now
6 with Headspace of actually providing mental health care in
7 enhanced primary care platforms for that age group and it
8 works extremely well. There's no problem in mixing
9 12-year-olds with 24-year-olds in that setting; it's
10 extremely effective I think.
11

12 And so, what we're saying here is that those Headspace
13 centres could be built upon, they could be expanded and
14 have this more specialised and multidisciplinary sort of
15 back-up system either built on to Headspace platforms or
16 built in association with these platforms and other primary
17 care and educational structures as it's described there.
18

19 There are a few options there about how to do that.
20 The advantage of actually integrating it fully with primary
21 care is that you don't have any barriers or triage systems
22 or transfer barriers getting in the way. We've been
23 piloting that in the northwest of Melbourne through our
24 Oxygen and Headspace system.
25

26 Q. Do the younger age group, 12, 13, 14 not have very
27 different needs to the upper end of that group?

28 A. There are differences in needs, but what they have in
29 common - I don't know if anyone in the room has been to a
30 music concert lately targeted at that age group, but even
31 in the cultural setting they mix very well. So, we have
32 had no problems with that whatsoever.
33

34 You can obviously focus on the needs of the person in
35 front of you, and there are different developmental issues
36 in early adolescence, from late adolescence of course, but
37 in terms of how comfortable they feel; and we've asked
38 them, I mean, every Headspace Centre has got a youth
39 advisory group and this has been a stable phenomenon for
40 over a decade. People thought that might be a problem when
41 we first started doing this, but it actually hasn't been.
42

43 Q. Can I ask you where the elderly fit into this model?

44 A. Well, we've had some debate in the advisory group and
45 the Commission about this, how engaged should we be about
46 aged care and aged psychiatry. I think we have to say
47 something about that, because obviously there are mental

1 disorders in the elderly, but you know, as you're aware,
2 this version is probably version 1 of a more definitive
3 sort of thing.
4

5 Q. Of course, and can I thank you for preparing version 1
6 of this model at our request. I want to change topics now
7 and ask you to elaborate on some of the views you've given
8 us in your statement, firstly about the current state of
9 the mental health system. You've said quite a bit about it
10 already but I'll try and ask you questions which don't
11 involve repeating what's already been said.
12

13 You start by talking about a very significant
14 opportunity, and you say that:

15
16 "The greatest unrealised opportunity in
17 Victoria's public health system is to
18 reduce the mortality and morbidity caused
19 by mental illness and, in contrast to
20 improvements in cancer and cardiovascular
21 disease, improvements in mental health by
22 these metrics have been negligible in
23 recent decades, indeed there's evidence
24 that these measures are getting worse."
25

26 How do those metrics compare?

27 A. Well, I guess, you know, everyone's aware that the
28 suicide toll is increasing in Australia. I think over 600
29 people in Victoria are currently dying every year. I've
30 certainly seen, in the part of Melbourne that I work, the
31 suicide rate in the age group that we try to treat with our
32 state funded Orygen Youth Health Service just climb year
33 after year.
34

35 Back 15 years ago we might have lost maybe one young
36 person every year or two, which was bad enough and when it
37 happened we went into major soul-searching about what we
38 should actually do to reduce that and everyone was
39 motivated to do that, we didn't accept that anyone should
40 die.
41

42 I've seen years now in the last few years where eight
43 or nine people have died in one year, which is absolutely
44 devastating because you know every single one of those
45 lives could have been saved if they'd had the right type of
46 help. So, there's the anecdotal but there's the numerical,
47 and I think NorthWestern Mental Health have actually mapped

1 the numbers of people who have actually died, not just from
2 suicides but homicides as well over that period.

3
4 It's devastating, and yet you know that we could do an
5 awful lot better if we implemented what we - if we were
6 resourced and if we implemented what we could do in that
7 regard.

8 Q. You've used the expression "the soft bigotry of low
9 expectations" in your statement, you've probably used it
10 elsewhere too. Can you say what you mean by that?

11 A. I think I've stolen that from George Bush's speech
12 writer; I think he was the first person to use that, which
13 is kind of strange.

14
15 How it's applicable in psychiatry is not just about
16 the deaths but about the low expectations that we've been
17 forced to have for recovery in our patients. Recovery is a
18 wonderful concept that the consumer movement has embraced
19 and we started thinking about it in the late 80s because we
20 believed people could recover. When I started psychiatry
21 people with schizophrenia were told you're never going to
22 recover, but we've seen large numbers of people with
23 schizophrenia recover if they get the right help, and even
24 with their own natural resilience in overcoming the
25 illness.

26
27 But the system is forced into just accepting that the
28 best that you can do for a patient is that they can be not
29 acutely unwell and bothering the emergency department,
30 that's essentially a good outcome as far as our mental
31 health system in Victoria is at the moment. If they're not
32 actually in your face in the emergency department, then
33 that's great.

34
35 And more subtly, if they're just at home and they're
36 reasonably happy and not suicidal or depressed, but not
37 working and just languishing, that's also okay. Whereas so
38 many more of those patients could actually have been having
39 what, you know, the National Mental Health Commission
40 called a contributing life, they could actually be much
41 more engaged socially, occupationally, vocationally if they
42 got the right sort of help, and the expectations that
43 people have for them, you know, that people believe that
44 that could be the case.

45
46 So, that's what I mean by "the soft bigotry of low
47 expectations". And it applies especially to illnesses like

1 schizophrenia, but it applies to a lot of people with
2 mental illness more generally.

3
4 Q. Earlier on you talked about the fact that the system
5 was envisaged in the 1990s as having a really strong
6 community-based mental health service. What are your views
7 about why that didn't get implemented in the manner it was
8 intended?

9 A. Well, I don't think governments realise the scale of
10 the problem. Essentially what kind of happened in the
11 first wave was, it was a question of just looking after the
12 same people but in a different setting; in other words, the
13 people who were the patients in the old mental hospital
14 system, people with more severe and enduring mental
15 illness, and the idea of new cohorts of patients coming in
16 with a different set of possibilities didn't seem to occur
17 to the people who were funding the initial wave of reform.
18

19 If I can use an analogy, I think the way it felt at
20 the time was that, we'd suddenly gone from a 19th Century
21 Alexander Bell phone system, and we suddenly got a first
22 generation mobile phone, which was a bit of a brick but
23 actually it was a big advance, and then we never went
24 through the iPhone, iPhone 2, iPhone 3, iPhone 4, which is
25 the only way that we would have actually done what they've
26 done in cancer and the other areas of health care: constant
27 improvement, constant - but the thing was not built to
28 scale and --
29

30 Q. Can you say what you mean by that?

31 A. Well, you know, no-one did the numbers on, you know,
32 like we're doing today: how many people in this catchment
33 area have a need for care? How is it going to be provided?
34 So population health planning. If there's 50,000 young
35 people in the western suburbs that need some kind of mental
36 health care and we're providing care for 800, what about
37 the other 49,200? What's happening to them? Out of that
38 49,000 are going to come the next wave of 800 more severely
39 ill. No-one thought that way, and you have to think that
40 way if you're going to have a system that's going to work
41 and keep people alive and recovering.
42

43 Q. Yes. You've said that "the quality of care provided
44 in acute inpatient is limited largely to risk management
45 and the acuity of the patients that can access the units is
46 high." Why do you think there's a focus on risk
47 management?

1 A. Well, I think it's not the fault of the people
2 operating those services; they realise that the only people
3 that get into hospital these days are absolutely in
4 life-threatening situations, and you're forced to deal with
5 the risk then, aren't you, because the risk has appeared.
6 But it means that it's impossible to do the sort of things
7 that used to happen in patient units, where people could
8 stay long enough until they were actually better and there
9 was some improvement in their condition. So, people are
10 discharged all the time now with very little improvement in
11 their condition.
12

13 I often think, you know, I was very motivated when I
14 worked in those old mental hospitals - people felt a bit
15 horrified by the way they were, but I don't think it's any
16 better, you know, those inpatient settings that I see now,
17 which is very, very disappointing to say that after all
18 this time.
19

20 But, you know, we thought it would be much better to
21 have very strong community services, like people didn't
22 have to spend weeks in hospital, which is what we were
23 trying to do. But now we've done neither, we've sort of
24 allowed the community system to sort of implode, and that
25 means that the residual acute system is under just such
26 enormous pressure that all they do is really try to keep
27 people alive and, it's a desperate situation actually, I'm
28 sure you've heard that from many other people.
29

30 Q. What do you think are the key things missing from the
31 community mental health services?

32 A. I think the freedom. I mean, they have become very
33 institutionalised as well in this - I think I used in my
34 statement, the idea of an iceberg sitting in the middle of
35 these hospital networks that just slowly melted over the
36 last 20 years. In those settings they don't even operate
37 efficiently because they're worried about risk, they've got
38 about 15 forms to fill in for every patient that they see.
39

40 I contrast it when I work in that system with when I
41 work in Headspace. I spend about five minutes at the end
42 of seeing a patient writing the notes, filling in a brief
43 evaluation. That's not the experience of people working in
44 the public mental health system, they're covering their
45 backs all the time because they know something's going to
46 go wrong with the patients and they're forced to do so by
47 the managers of those systems.

1
2 So, the system's not efficient, the morale has sunk,
3 the leadership has ground down over the years, I would say.
4 I've seen these people, directors of services that are
5 struggling to sort of, you know - an impossible job really.
6 So, it isn't even operating as well as it could with the
7 level of resourcing that it has because of these other
8 cultural factors which, you know, have not been addressed.
9

10 Q. You've used the expression "sitting there like an
11 iceberg which has slowly melted", do you mean to say by
12 that that it's never been properly integrated?

13 A. Yeah, I don't think it's been integrated, but
14 integration has been seen through the hospital lens rather
15 than the community lens. So, the community system should
16 have been integrated with the community and with primary
17 care, not with, you know, emergency departments; it's gone
18 the other way.
19

20 Q. If you take a bit of a broader lens to the mental
21 health system as a whole, how has its progress since the
22 1990s compared with progress in the treatment and
23 management of other non-communicable diseases?

24 A. Well, it's very stagnant, I think. I think, if I can
25 quote Christine Kilpatrick, the current CEO of Melbourne
26 Health, she went to the Children's for ten years, came back
27 to Melbourne Health, and said nothing had really changed in
28 mental health, if anything it had got worse. And
29 contrasted with the progress that she'd seen in cancer and
30 cardiovascular medicine and all these other things.
31

32 One of the reasons for that is because they respect
33 expertise in those specialities, they respect research, and
34 they try to get the latest research advances translated to
35 real people.
36

37 In mental health, the culture of mental health care
38 resists all that, it's suspicious of research, it's
39 suspicious of expertise, and we've got to make sure that
40 the things that work and the things that will get people
41 better are supported by everybody, and so that the
42 consumers are involved in that and they understand how
43 that's going to benefit them and they can help us do the
44 research.
45

46 We do that at Orygen, we have a research council of
47 young people that help us design studies so that we're

1 doing relevant things, and also that they will then be
2 accepted and embraced by the patients; just like you see in
3 cancer where, you know, patients are very supportive of
4 research and very supportive of expertise.

5
6 Q. Why do you think there are such big differences
7 between the way in which general health has developed and
8 the way in which mental health has developed?

9 A. I think it's just a pure matter of discrimination and
10 stigma.

11
12 Q. What do you mean by that?

13 A. Well, the stigma's rife within the health professions,
14 it's rife within the medical research environment. We
15 don't get a fair deal. The patients that - the people who
16 experience mental illness are discriminated against, but so
17 are we as mental health professions.

18
19 Q. Are you referring to a sort of institutionalised
20 stigma?

21 A. Yeah.

22
23 Q. I said I was going to ask you before why it was that
24 you said "we're just not delivering even the really good
25 things that we have available, they're not reaching
26 people", why do you think that is?

27 A. Well, in medicine generally there's this
28 implementation failure problem and, you know, our
29 colleagues in other branches of health care would say
30 that's an issue as well; you know, the delay between an
31 advance and when it's actually implemented in the real
32 world.

33
34 But people make huge efforts to accelerate that in
35 other areas of health care. Every time a new cancer drug
36 comes on the scene there's tremendous pressure on the
37 Health Minister to tick it off and finance it. It doesn't
38 matter if it's hundreds of millions of dollars, it will be
39 approved very, very quickly and that's not the case with
40 us.

41
42 I'll give you one example, TMS, for treatment of
43 resistant depression.

44
45 Q. Can you say what TMS is?

46 A. Transcranial magnetic stimulation. Very safe, it
47 sounds a bit science fiction, but it's actually very safe

1 and it improves brain plasticity. If someone hasn't
2 responded to CBT and antidepressants, rather than trying
3 lots of different antidepressants, the next step should be,
4 the success rate is much better if you go to TMS. But that
5 is not funded, it's not supported, it's not available, it's
6 been known about for many years, and this is one example.

7
8 Q. Speaking about funding on a broader scale, you said
9 earlier that the system was not scaled or designed for
10 scale when it was changed in the early 1990s. You've said
11 also that it was not funded to address the scale of the
12 problem. What's the significance of the funding gap in all
13 of the difficulties that you've been talking about?

14 A. Well, there was a landmark publication in October
15 last year from the Lancet which is on the global - the
16 Global Mental Health Commission, it's called, and it sort
17 of mapped the treatment gap all around the world and it
18 showed that governments around the world generally spend
19 about 2 per cent of the health budget on mental health care
20 and it's variable, but anywhere from 12-15 per cent of the
21 burden of disease. So, this is a massive issue across the
22 whole world. Yeah, it's just the shortfall between what
23 the need is and what the level of funding provision there
24 is.

25
26 And, you know, in Australia it's probably about
27 6 per cent of the health budget; people debate that. The
28 most accurate estimate in Australia is about 14.6 per cent
29 of the health burden so that means a treatment gap.

30
31 In Victoria, as you know, it's in common knowledge
32 now, that we're covering about 1 per cent of the Victorian
33 population with state government resources, and if you
34 believe they're supposed to cover 3 per cent, that's the
35 treatment gap right there for the seriously mentally ill.
36 That doesn't exist in cancer and other health areas in the
37 same way.

38
39 Q. And so, you're saying there's a very good economic
40 case for changing that?

41 A. Yeah, I mean, the beauty - the best news and the best
42 thing we could focus on, which the Productivity Commission
43 is obviously focusing on, is that we are different in a
44 very good way from the rest of health care.

45
46 Because, you know, obviously we want to keep treating
47 cancer in a very good way. We're definitely not saying,

1 it's not cancer envy we're talking about here, it's cancer
2 admiration in a way. But treating cancer is a highly
3 cost-ineffective thing to do, because it's mostly older
4 people who are beyond - or not totally beyond, but many of
5 them are beyond the productive phase of their life and yet
6 we still want to care for them and treat them. But it's
7 not going to be a great investment in terms of
8 cost-effectiveness.

9
10 Mental illness, because it strikes in the prime
11 productive years of life in young people on the threshold
12 of productive life, and people across the adult years of
13 life, it's a massive opportunity. Because, if you get even
14 a substantially higher proportion of people well and
15 productive, which is very achievable, it's going to pay for
16 itself several times over.

17
18 We ourselves have done cost-effectiveness studies of
19 treatment of psychosis, early intervention for psychosis,
20 and there's a whole range of evidence suggesting that if
21 mental illness was treated more effectively it would pay
22 for itself several times over through reduced welfare
23 payments, reduced expenditure on a whole range of other
24 government activities, including prisons, homelessness and
25 so on.

26
27 Q. Can I ask you a couple of questions about governance.
28 You said in your statement that the:

29
30 "The governance and financial model
31 underpinning the current system exposed it
32 to major vulnerability at the hands of
33 general hospital administrators."

34
35 What do you mean by that?

36 A. Well, we've already talked about the issue of it not
37 being funded to scale and us not having appropriate
38 financial models, like for example the NDIS, to drive the
39 sort of level of investment that we really need. But even
40 the amount of money that was allocated or has been
41 allocated to public mental health care in Victoria has not
42 always found its way to the mentally ill because of the way
43 that the money is given in a block-funded way to large
44 hospital networks; it's not activity-based, so it's sitting
45 there like a big cash cow in the hospital network.

46
47 And obviously, when pressures come in other parts of

1 the health system the CO is very tempted to find ways to
2 divert some of that funding into other forms of mental
3 health care. It absolutely happens.

4
5 The other thing, to blame the Health Department as
6 well as the hospitals, the Health Department has
7 underfunded the bed day rate for many years and that meant
8 that the hospital CO had to subsidise the bed day rate
9 somehow and they would do that through raiding the
10 community mental health resources, which then destabilised
11 a very fragile system even further and helped to cause it
12 to implode. So, they would freeze positions in the
13 community or collapsed them so that funding could be
14 diverted more easily. We've seen this happen in many
15 settings

16
17 Q. So you're saying there's both a funding shortfall and
18 a structural funding design problem?

19 A. Yeah, and the Health Department is aware of this and
20 is apparently powerless to stop it with the current
21 governance model.

22
23 Q. Can you say a little bit more about the current
24 governance model and specifically in that context. Sorry,
25 when you say governance model, governance of what?

26 A. Governance of the inpatient beds and the community
27 mental health clinics and community resources.

28
29 Q. Yes.

30 A. So that's currently run through acute hospital
31 networks basically, all of that. And it's a bit of an
32 anomaly as I said earlier, the community resources being
33 under the wing of those sort of structures, because they
34 really do very little of that apart from mental health.

35
36 Q. Alright. We have asked you, not just what is wrong
37 but what are the critical elements of a well functioning
38 mental health system and you've said this:

39
40 "Much more effective and mandated
41 professional leadership is needed from
42 senior psychiatrists who should be
43 empowered to oversee the clinical
44 governance of the whole system they lead."

45
46 Can you please elaborate on that?

47 A. Well, back when, I suppose, things were looking a

1 little bit more optimistic, a lot of the leadership of
2 these systems was people who had often a dual clinical and
3 academic background, so they were clinical experts but they
4 also had research credibility and status so they were
5 respected and they were in charge of the service; and the
6 manager would report to them for the budget, so the
7 leadership was content-based.

8
9 That was gradually split and so the managers were in
10 control, and gradually the medical role was marginalised to
11 just looking after the medical staff; not even the other
12 clinical staff. So, that is not the way they run, you
13 know, cardiology or neurology or other structures like that
14 as I understand it, and so, that had a lot of negative
15 consequences.

16
17 And so, the person that was left with the Mental
18 Health Act responsibilities as the authorised psychiatrist
19 and the medical leader carried all the risk and all the
20 pressure but none of the ability to actually influence as
21 much what was done within the service, so that was
22 definitely a negative.

23
24 So I think somehow we've got to make those leadership
25 positions more attractive, and also, to actually train and
26 recruit and groom and nurture the next generation of
27 leadership, because the current generation has wilted in
28 the face of these sorts of pressures.

29
30 Q. On governance you also say that:

31
32 "The governance of community mental health
33 services needs to be separated and fully
34 protected from the governance of acute
35 systems of care.

36
37 A. Well, this is a tricky one because, I think it's very
38 important that mental health care remains a health system
39 issue and doesn't just become consigned to a purely social
40 view of things. I mean, the social thing is very, very
41 important in psychiatry and mental health, and so, you want
42 a holistic model that includes, you know, psycho-social and
43 integrates them with the medical and the biological side of
44 things. But you do not want to remove the medical and the
45 scientific perspective from the thing, so it has to be
46 somehow kept within the health realm, but I would like to
47 see a much broader health realm so it's holistic so it's

1 got other much broader foci.

2

3 But I think what I'm trying to say, is that, putting
4 that in the hands of hospital-centric thinking, it's really
5 the tail wagging the dog, because most of the care of
6 people with mental ill-health has to happen in their
7 communities, where they live, and integrated with the
8 primary care and other social structures. So how to do
9 that is a challenge, you know.

10

11 Q. Can I ask you finally, Professor McGorry, apart from
12 the specific work you're doing in Headspace and Orygen,
13 what about the - what features or feature of the mental
14 health system makes you even a little bit optimistic that
15 we can change positively?

16 A. I'm incredibly optimistic. I think we're at a
17 point now where the whole community, as we can see through
18 this Royal Commission is - it's an authorising environment,
19 I think I heard the CEO say yesterday.

20

21 We're empowered now, and the community is empowering
22 this change, and it's happening all around the world. We
23 have contracts with the World Economic Forum in globalising
24 the Youth Mental Health Model I've been talking about here.

25

26 We have the Lancet, the very important Medical Journal
27 in the UK, producing commissions on mental health, on
28 depression, on youth mental health, we're embarking on that
29 now.

30

31 We've got the Productivity Commission looking at the
32 cost of not spending enough money on mental health care -
33 that's the way I like to look at what they're doing. And
34 we've got this Royal Commission here which is actually
35 telling the truth about what's been happening in Victoria
36 for the last 15 years or so and exposing that truth, but in
37 a way that's solution-focused.

38

39 We have the ability to design, create and resource a
40 new way of doing things. It has to be new. Everything
41 that I've done in psychiatry has been creating something
42 new, not trying to patch up some old system. So, moving
43 out of the older asylums into EPPIC, and now into
44 Headspace, creating new cultures of care within the health
45 system, within the health and social system, but not
46 actually trying to, you know, defend the indefensible and
47 do things that don't work.

1
2 And so, I do feel very optimistic but it has to be a
3 real sea-change. We, among all countries in the world and
4 in all states in Australia, have got the ability to do
5 that. Victoria, I've seen it happen before, all the
6 innovations in mental health in Australia have come out of
7 this state, and yet, they haven't been nurtured. But we
8 have got the ability here to do this and we've got the
9 support of the public generally and, you know, I feel very
10 confident and optimistic that something positive should
11 happen now.

12
13 MS NICHOLS: Thank you very much, Professor McGorry.
14 Chair, do the Commissioners have questions?

15
16 COMMISSIONER McSHERRY: Q. Thanks very much for your
17 advice and your statement. I'd just like to ask a little
18 bit more about your model because I think it's really
19 important for us to get some ideas of the alternatives that
20 might exist to the current system. We've been hearing a
21 lot about what's not working.

22
23 So, can I just, for a point of clarification, are you
24 dividing these cohorts up into three main age groups?
25 Because I see that there's the over 25s is mentioned twice,
26 and I'm not quite sure why?

27 A. I think that's meant to depict within a region of
28 Melbourne you might need a couple of these adult platforms
29 and maybe only one of the youth and child ones. So, it's
30 really just a - what's the word - a proportional thing.

31
32 Q. I see.

33 A. And I don't meant to suggest that these things should
34 be impermeable either. I totally agree with what Ric
35 Haslam said this morning, that these boundaries should be a
36 little bit more flexible, so not just rigid necessarily
37 chronological age, but if someone's deemed to be
38 developmentally different, then you should have some
39 leeway. And so, the under-resourcing has led to absolute
40 rigidity about these sort of things in the past.

41
42 Q. How would such a model work in regional areas?

43 A. That's a good question. I think you can get things
44 down to a reasonable population size with this type of
45 model, I would say, but not probably below 50,000 or
46 100,000 people; so, smaller. We've already seen this with
47 Headspace, that Headspace probably needs a population base

1 of about 20,000 or 30,000 before it becomes unviable, and
2 then you need a more flexible outreach type model beyond
3 that.
4

5 So, it is more of a challenge in regional, and this is
6 really, I suppose, what we've provided so far is more like
7 a metro or suburban sort of model or maybe a large regional
8 town, but we would have to do some more designing to try to
9 work out how we could link, you know, more rural and remote
10 areas into such a model.
11

12 Q. I'm also thinking it would have to be adaptable to
13 certain communities, you know, particularly for CALD
14 groups?

15 A. Yeah.
16

17 Q. But, you know, LGBTIQ groups that may not want to go
18 to just a one-stop shop, but it might be community-led
19 one-stop shops, things like that?

20 A. Flexibility is always good, but having that said, with
21 Headspace LGBTIQ is probably about maybe 13 per cent
22 nationally of the clientele in Headspace. But there are
23 some Headspace like in Collingwood where it's 45 per cent,
24 but still the basic elements of Headspace work but the
25 culture is obviously tailored then in a different way, so
26 you have to have flexibility, I agree.
27

28 COMMISSIONER McSHERRY: Thanks for that clarification.
29

30 COMMISSIONER COCKRAM: Q. Thank you, Professor McGorry.
31 I wanted to continue to explore the model. My first
32 question really was about the growing interest and evidence
33 around peer-led models and peer-led workforce.
34

35 I see a statement in each of these, but how do you see
36 actually the role in a leadership way of peer-led models in
37 this community-based design?

38 A. Thank you for that question. I think it's incredibly
39 important because we've had such positive experiences with
40 peer - or with youth engagement within the Headspace
41 system. It couldn't have been developed successfully
42 without that, actually.
43

44 We now have youth peer workers in Headspace and that's
45 a growing thing, but they were involved in the design and
46 also every Headspace has a youth advisory group, and I
47 think more could be done in terms of - as you're alluding

1 to - in terms of leadership as well. We would like to see
2 young people in the youth mental health model involved in
3 management and also on boards as well, so definitely that's
4 the direction it's heading in.

5
6 Q. One of the other things I was wanting to ask about is
7 that, the residential component of this looks very much
8 like an inpatient environment. Do you think there's a
9 place for other residential models in community?

10 A. Well, what we've termed there "therapeutic residential
11 unit" is really modeled on the PARC idea, which we think
12 has been a piece of progress. But one way we think that
13 PARC could be improved is by having more therapeutic
14 programs within them, so they're not just residential
15 programs, they actually have the sort of therapeutic
16 expertise that some of the Scandinavian models that we've
17 seen in the past can offer.

18
19 So, there's a way that PARC can be improved further,
20 but it's essentially, I suppose, a subacute longer stay
21 model that's meant to indicate building on the PARC
22 experience.

23
24 Q. One final question from me. In Victoria we have the
25 benefit of having a community health model. We've talked
26 about the relationship between some of this design and
27 Headspace models. Where do you see the community health
28 model fitting in here?

29 A. Yeah, I think it's a great question too. I mean, in a
30 way these hubs should be like community health centres,
31 because you want to have physical health totally integrated
32 within them, and that also helps with stigma as well, I
33 think, if they're more holistic.

34
35 But I suppose the trick is going to be, how do you get
36 the really high quality mental health expertise available
37 within such models? So exploring how that could relate to
38 community health would be a great way to take this further.

39
40 COMMISSIONER COCKRAM: Thank you.

41
42 CHAIR: Professor Fels.

43
44 COMMISSIONER FELS: Q. Thanks very much for your
45 excellent witness statement as well as your evidence. I
46 was about to ask the same question as Dr Cockram, but just
47 to follow it through on the therapeutic residential unit.

1 I suppose there's also some longer term residential needs
2 of people with long-term mental illness. Do you have any
3 thoughts on that?

4 A. Absolutely. And I think we tried to indicate that
5 with the continuing care unit at the top.

6
7 Q. Ah, yes.

8 A. So that's meant to be - and there may be a need for
9 much greater resourcing of that too, because these
10 currently do exist but they're probably in short supply, so
11 I think that's absolutely (indistinct). Because when the
12 old institutions were closed there were a lot of people who
13 had a need for that sort of service and that was - it was
14 actually constrained probably to a much greater extent than
15 it should have been.

16
17 Q. One other brief thing. You expressed some optimism
18 about the attitudes of younger people being improved in the
19 stigma dimension. We heard some evidence, talking about
20 the general population, that attitudes don't seem to have
21 improved, they may have got a little bit worse with respect
22 to schizophrenia and serious forms of illness. Do you have
23 any impressions whether this improvement in the younger
24 generation extends to people with serious mental illness?

25 A. Yeah, I think it has, and that's because we've kind of
26 softened the kind of - what's the word - the stereotype of
27 schizophrenia. I mean, we deliberately did that with the
28 early psychosis movement. We tried to say, schizophrenia
29 is just a subtype of psychosis and something you'll hear
30 about, but we tried to take that, I suppose, that toxic
31 message that was built into the schizophrenia concept, that
32 you couldn't recover.

33
34 I can't tell you how many times I've heard stories of
35 psychiatrists telling patients that you've got
36 schizophrenia, you're not going to be able to work, you've
37 got to have a more - so that's the soft bigotry of low
38 expectations again.

39
40 So I think in young people that's been quite
41 successful in terms of softening the whole idea about - and
42 having a much more optimistic approach to psychotic
43 illnesses, that recovery is more possible.

44
45 I think you're right, though, in the general
46 population there's been a lot of success in reducing the
47 stigma across all ages for anxiety and depression, but very

1 little effort's been put into destigmatising terms like
2 borderline and schizophrenia and more serious forms of
3 mental illness.
4

5 I mean, when you spend tens of millions of dollars on
6 anxiety and depression - Beyond Blue, but virtually
7 nothing, you know, through SANE and other organisations for
8 the other types of mental illness, then that's probably
9 inevitable, isn't it? So, a much bigger effort needs to be
10 put into that, if that's what's behind your question.
11

12 COMMISSIONER FELLS: Yes, thank you.
13

14 CHAIR: Q. Professor McGorry, one other thing from me.
15 In terms of material that's come before us and you also
16 reference this in your witness statement, a lot of the
17 current mental health system is balanced around brief
18 episodes of care, and sometimes we've heard, and even today
19 we heard about one night's admission to an inpatient unit,
20 or ten episodes of psychological assistance, and for many
21 consumers we hear them say that raises great anxiety, about
22 what happens if I'm not fixed in that period of time or I
23 need ongoing care.
24

25 You do reference that some people will need longer
26 term team-based care, and even go on in your witness
27 statement to suggest some might also need a concept of
28 "mobile assertive outreach in the community". Can you talk
29 about how in the models of the future you think we
30 reconcile these tensions between brief episodes of care and
31 longer term care models that might be required?

32 A. Yeah, thank you, that's a really, really important
33 question. Well, as you say, I mean, the episode of care
34 for acute inpatient care is maybe about eight or ten days;
35 you know, way too short for most people.
36

37 But then, when they're discharged to the current
38 community clinics, their half-life - if I can use that term
39 - is about six to 12 months across Victoria. So, you get a
40 few months of after care, basically, and then you get sent
41 back to the GP until the next relapse occurs, so even that
42 episode of care is too short.
43

44 And in our services at Orygen, originally arising out
45 of the Epic model, we managed to guarantee two years of
46 care, that was when we had enough resources to provide when
47 we called it "the critical period" which I was referring to

1 before. So, that was an advance on what adult services
2 could provide, generally speaking, but it's still not
3 enough for a significant minority of the patients; maybe
4 over 50 per cent need up to five years, and maybe
5 10 per cent or more, 20 per cent, need very long-term care.
6 And they should have access to expert care, not just
7 general practice - that's the problem.

8
9 So, when you're talking about episodes of care, it's
10 at what level of care you can get. Probably everyone's got
11 access to general practice - so, if that's an episode of
12 care, that could be long-term, but it's insufficient for
13 what these patients need, and so, I think in that sense -
14 and the other thing I'm sure that the consumers have been
15 saying in the Commission is. We want to have the same
16 person to look after us all that time, you know.

17
18 I've looked after patients in the west of Melbourne,
19 for some of them for over 30 years, and the value of that
20 is - you can't put a price on it, you know, the
21 relationship that you have with a person over that time.
22 So, those are really important things.

23
24 In terms of the assertive community treatment and the
25 home-based treatment, those are very powerful strategies.
26 I've worked in those teams, it's a joy to work in those
27 teams, that's a fantastic way to work if they're well
28 resourced and if you've got the right type of skilled,
29 gifted people working in those teams. So, we've got to put
30 a lot of effort into finding those wonderful people to work
31 in those teams who are skilled and properly supported.

32
33 I think all of these things are achievable with money
34 and with the right leadership and planning.

35
36 MS NICHOLS: May Professor McGorry be excused?

37
38 CHAIR: Thank you.

39
40 <THE WITNESS WITHDREW

41
42 MS NICHOLS: That concludes the evidence for today,
43 Commissioners.

44
45 **AT 3.40PM THE COMMISSION WAS ADJOURNED TO**
46 **MONDAY, 8 JULY 2019 AT 10.00AM**
47

0	315:22, 315:45, 316:26, 317:42, 317:43, 317:45, 318:7, 318:12, 318:16, 318:19, 318:29, 324:38, 326:30, 332:11, 337:15, 338:5, 349:35, 352:38, 359:36	2016 [5] - 270:41, 294:20, 295:21, 297:37, 297:41 2018 [1] - 271:14 2019 [2] - 263:18, 365:46 20s [3] - 318:2, 325:27, 329:20 21 [2] - 265:5, 304:27 21-year-old [1] - 264:12 24-year-olds [1] - 348:9 25 [4] - 324:38, 324:47, 325:9, 330:23 25-30 [1] - 326:3 25s [1] - 360:25 26 [4] - 295:22, 326:37, 326:40, 326:42 280 [1] - 339:34	6	abrupt [1] - 274:45 absence [2] - 309:34, 309:37 absolute [1] - 360:39 Absolutely [1] - 296:23 absolutely [28] - 279:40, 289:8, 291:25, 294:6, 295:12, 296:4, 296:35, 297:11, 298:27, 299:31, 301:16, 301:35, 301:42, 323:23, 324:5, 324:22, 325:22, 332:4, 335:7, 337:33, 338:28, 341:14, 345:21, 349:43, 352:3, 357:3, 363:4, 363:11 abuse [3] - 284:30, 319:12, 332:9 academic [5] - 295:34, 295:37, 298:15, 332:31, 358:3 academically [1] - 295:38 Academy [2] - 322:8, 322:9 accelerate [1] - 354:34 accept [4] - 326:14, 338:19, 338:21, 349:39 accepted [1] - 354:2 accepting [1] - 350:27 access [61] - 264:26, 269:44, 273:27, 273:41, 273:44, 274:5, 274:8, 275:5, 275:20, 275:32, 281:9, 281:12, 285:16, 289:31, 289:37, 289:41, 290:16, 290:23, 291:27, 291:39, 292:28, 297:2, 301:14, 301:19, 301:30, 303:23, 303:24, 310:6, 310:43, 311:4, 311:17, 311:24, 316:18, 319:28, 323:46, 324:31, 324:33, 326:26, 326:45, 327:6, 327:25, 328:23, 328:24, 328:34, 330:7, 330:9, 331:13, 339:4,	
0-2 [2] - 323:33, 323:37 0-11 [2] - 345:36, 347:25 0-12 [1] - 330:4 0-18 [4] - 303:4, 305:6, 315:6, 328:43 0-2 [1] - 305:15 0-25 [6] - 303:29, 315:8, 316:11, 316:21, 329:46, 330:1 0-4 [2] - 305:8, 305:14	15-25 [2] - 303:20, 315:7 15-year-old [2] - 307:39, 317:31 15-year-olds [1] - 317:28 16 [7] - 265:26, 266:7, 267:1, 307:23, 310:8, 318:29, 338:5 16-18 [1] - 330:44 16-65 [1] - 328:44 17 [1] - 269:42 17-year-old [2] - 269:24, 269:27 17th [1] - 268:43 18 [10] - 266:4, 307:23, 310:8, 313:24, 315:38, 325:12, 326:33, 327:23, 328:41, 328:44 18-24 [1] - 326:36 18-year-old [1] - 307:40 18-year-olds [2] - 270:23, 275:23 18th [1] - 306:13 1990s [4] - 344:34, 351:5, 353:22, 355:10 19th [1] - 351:20	2016 [5] - 270:41, 294:20, 295:21, 297:37, 297:41 2018 [1] - 271:14 2019 [2] - 263:18, 365:46 20s [3] - 318:2, 325:27, 329:20 21 [2] - 265:5, 304:27 21-year-old [1] - 264:12 24-year-olds [1] - 348:9 25 [4] - 324:38, 324:47, 325:9, 330:23 25-30 [1] - 326:3 25s [1] - 360:25 26 [4] - 295:22, 326:37, 326:40, 326:42 280 [1] - 339:34	6-8 [1] - 343:26 60 [3] - 299:7, 340:14, 340:21 600 [1] - 349:28		
1	1 [3] - 349:2, 349:5, 355:32 1.5 [1] - 343:24 10 [6] - 312:35, 319:7, 326:30, 339:29, 343:12, 365:5 10-12 [1] - 325:7 10.00am [1] - 263:18 10.00AM [1] - 365:46 10.03am [1] - 264:43 10.33am [1] - 276:9 100,000 [1] - 360:46 11 [4] - 265:17, 267:24, 346:46, 347:10 11.36am [1] - 293:15 11.56am [1] - 302:18 12 [9] - 265:18, 270:42, 277:19, 298:29, 310:8, 329:9, 348:5, 348:26, 364:39 12-15 [1] - 355:20 12-25 [3] - 329:40, 330:4, 347:43 12-year-olds [1] - 348:9 13 [12] - 267:19, 274:19, 303:7, 306:13, 306:16, 309:28, 311:29, 314:6, 314:12, 326:43, 348:26, 361:21 13-18 [1] - 303:38 14 [2] - 317:43, 348:26 14.6 [1] - 355:28 15 [26] - 267:19, 274:19, 306:25, 308:20, 308:27, 313:24, 314:37,	16 [7] - 265:26, 266:7, 267:1, 307:23, 310:8, 318:29, 338:5 16-18 [1] - 330:44 16-65 [1] - 328:44 17 [1] - 269:42 17-year-old [2] - 269:24, 269:27 17th [1] - 268:43 18 [10] - 266:4, 307:23, 310:8, 313:24, 315:38, 325:12, 326:33, 327:23, 328:41, 328:44 18-24 [1] - 326:36 18-year-old [1] - 307:40 18-year-olds [2] - 270:23, 275:23 18th [1] - 306:13 1990s [4] - 344:34, 351:5, 353:22, 355:10 19th [1] - 351:20	2016 [5] - 270:41, 294:20, 295:21, 297:37, 297:41 2018 [1] - 271:14 2019 [2] - 263:18, 365:46 20s [3] - 318:2, 325:27, 329:20 21 [2] - 265:5, 304:27 21-year-old [1] - 264:12 24-year-olds [1] - 348:9 25 [4] - 324:38, 324:47, 325:9, 330:23 25-30 [1] - 326:3 25s [1] - 360:25 26 [4] - 295:22, 326:37, 326:40, 326:42 280 [1] - 339:34	7	75 [1] - 324:47
1 [3] - 349:2, 349:5, 355:32 1.5 [1] - 343:24 10 [6] - 312:35, 319:7, 326:30, 339:29, 343:12, 365:5 10-12 [1] - 325:7 10.00am [1] - 263:18 10.00AM [1] - 365:46 10.03am [1] - 264:43 10.33am [1] - 276:9 100,000 [1] - 360:46 11 [4] - 265:17, 267:24, 346:46, 347:10 11.36am [1] - 293:15 11.56am [1] - 302:18 12 [9] - 265:18, 270:42, 277:19, 298:29, 310:8, 329:9, 348:5, 348:26, 364:39 12-15 [1] - 355:20 12-25 [3] - 329:40, 330:4, 347:43 12-year-olds [1] - 348:9 13 [12] - 267:19, 274:19, 303:7, 306:13, 306:16, 309:28, 311:29, 314:6, 314:12, 326:43, 348:26, 361:21 13-18 [1] - 303:38 14 [2] - 317:43, 348:26 14.6 [1] - 355:28 15 [26] - 267:19, 274:19, 306:25, 308:20, 308:27, 313:24, 314:37,	2	2 [3] - 321:17, 351:24, 355:19 2.01pm [1] - 321:28 20 [9] - 267:35, 303:18, 312:36, 315:15, 331:34, 343:22, 344:45, 352:36, 365:5 20,000 [1] - 361:1 20-odd [1] - 344:47 2005 [1] - 340:3 2007 [1] - 326:44 2014 [1] - 319:17 2015 [4] - 265:26, 265:29, 267:23, 270:17	3	8 [2] - 343:12, 365:46 800 [3] - 331:36, 351:36, 351:38 80s [1] - 350:19	
1 [3] - 349:2, 349:5, 355:32 1.5 [1] - 343:24 10 [6] - 312:35, 319:7, 326:30, 339:29, 343:12, 365:5 10-12 [1] - 325:7 10.00am [1] - 263:18 10.00AM [1] - 365:46 10.03am [1] - 264:43 10.33am [1] - 276:9 100,000 [1] - 360:46 11 [4] - 265:17, 267:24, 346:46, 347:10 11.36am [1] - 293:15 11.56am [1] - 302:18 12 [9] - 265:18, 270:42, 277:19, 298:29, 310:8, 329:9, 348:5, 348:26, 364:39 12-15 [1] - 355:20 12-25 [3] - 329:40, 330:4, 347:43 12-year-olds [1] - 348:9 13 [12] - 267:19, 274:19, 303:7, 306:13, 306:16, 309:28, 311:29, 314:6, 314:12, 326:43, 348:26, 361:21 13-18 [1] - 303:38 14 [2] - 317:43, 348:26 14.6 [1] - 355:28 15 [26] - 267:19, 274:19, 306:25, 308:20, 308:27, 313:24, 314:37,	3	3 [3] - 304:17, 351:24, 355:34 3.40PM [1] - 365:45 30 [2] - 312:39, 365:19 30,000 [1] - 361:1 300,000 [1] - 343:18 31 [1] - 326:44	8	8 [2] - 343:12, 365:46 800 [3] - 331:36, 351:36, 351:38 80s [1] - 350:19	
1 [3] - 349:2, 349:5, 355:32 1.5 [1] - 343:24 10 [6] - 312:35, 319:7, 326:30, 339:29, 343:12, 365:5 10-12 [1] - 325:7 10.00am [1] - 263:18 10.00AM [1] - 365:46 10.03am [1] - 264:43 10.33am [1] - 276:9 100,000 [1] - 360:46 11 [4] - 265:17, 267:24, 346:46, 347:10 11.36am [1] - 293:15 11.56am [1] - 302:18 12 [9] - 265:18, 270:42, 277:19, 298:29, 310:8, 329:9, 348:5, 348:26, 364:39 12-15 [1] - 355:20 12-25 [3] - 329:40, 330:4, 347:43 12-year-olds [1] - 348:9 13 [12] - 267:19, 274:19, 303:7, 306:13, 306:16, 309:28, 311:29, 314:6, 314:12, 326:43, 348:26, 361:21 13-18 [1] - 303:38 14 [2] - 317:43, 348:26 14.6 [1] - 355:28 15 [26] - 267:19, 274:19, 306:25, 308:20, 308:27, 313:24, 314:37,	4	4 [4] - 263:20, 268:37, 341:12, 351:24 40 [4] - 266:46, 267:3, 340:26, 340:32 45 [3] - 266:46, 271:18, 361:23 45-50 [1] - 327:7 49,000 [1] - 351:38 49,200 [1] - 351:37	9	9 [1] - 319:7 90-130 [1] - 263:12 90s [2] - 335:26, 337:47 95 [1] - 330:33	
1 [3] - 349:2, 349:5, 355:32 1.5 [1] - 343:24 10 [6] - 312:35, 319:7, 326:30, 339:29, 343:12, 365:5 10-12 [1] - 325:7 10.00am [1] - 263:18 10.00AM [1] - 365:46 10.03am [1] - 264:43 10.33am [1] - 276:9 100,000 [1] - 360:46 11 [4] - 265:17, 267:24, 346:46, 347:10 11.36am [1] - 293:15 11.56am [1] - 302:18 12 [9] - 265:18, 270:42, 277:19, 298:29, 310:8, 329:9, 348:5, 348:26, 364:39 12-15 [1] - 355:20 12-25 [3] - 329:40, 330:4, 347:43 12-year-olds [1] - 348:9 13 [12] - 267:19, 274:19, 303:7, 306:13, 306:16, 309:28, 311:29, 314:6, 314:12, 326:43, 348:26, 361:21 13-18 [1] - 303:38 14 [2] - 317:43, 348:26 14.6 [1] - 355:28 15 [26] - 267:19, 274:19, 306:25, 308:20, 308:27, 313:24, 314:37,	5	5 [2] - 263:18, 294:38 50 [7] - 277:2, 289:23, 325:43, 325:47, 326:3, 329:26, 365:4 50,000 [3] - 331:37, 351:34, 360:45 580 [1] - 293:29	A	ability [7] - 269:46, 298:41, 337:39, 358:20, 359:39, 360:4, 360:8 able [35] - 269:2, 269:20, 270:25, 271:28, 274:5, 277:34, 280:8, 281:15, 287:38, 294:12, 295:6, 295:33, 296:15, 296:26, 297:2, 297:5, 297:17, 298:33, 298:37, 301:15, 301:19, 301:44, 308:22, 310:6, 312:47, 316:17, 320:11, 326:45, 327:6, 329:36, 331:42, 334:14, 338:10, 338:43, 363:36 abnormal [3] - 269:40, 270:1, 275:9 Aboriginal [3] - 283:47, 284:46, 304:39	

<p>339:46, 340:35, 340:37, 340:39, 343:4, 343:34, 344:1, 344:4, 344:13, 344:14, 351:45, 365:6, 365:11</p> <p>Access [3] - 310:14, 312:29, 343:2</p> <p>accessible [2] - 273:38, 317:8</p> <p>accessing [12] - 284:1, 284:38, 285:4, 289:5, 289:14, 289:15, 291:15, 309:25, 326:41, 327:20, 343:37, 343:44</p> <p>according [5] - 322:34, 331:44, 331:46, 334:30, 346:43</p> <p>accrete [1] - 311:39</p> <p>accumulation [1] - 312:9</p> <p>accumulative [1] - 311:37</p> <p>accurate [1] - 355:28</p> <p>achievable [2] - 356:15, 365:33</p> <p>achieve [2] - 334:40, 335:11</p> <p>achieving [1] - 337:29</p> <p>acknowledged [1] - 265:37</p> <p>Act [1] - 358:18</p> <p>activities [3] - 298:32, 299:18, 356:24</p> <p>activity [2] - 311:10, 356:44</p> <p>activity-based [1] - 356:44</p> <p>actual [3] - 286:46, 290:14, 301:7</p> <p>acuity [4] - 280:40, 310:5, 315:43, 351:45</p> <p>acute [14] - 272:11, 281:12, 315:46, 330:24, 344:37, 345:5, 345:6, 346:3, 346:28, 351:44, 352:25, 357:30, 358:34, 364:34</p> <p>acutely [3] - 275:13, 344:19, 350:29</p> <p>adaptable [1] - 361:12</p> <p>add [3] - 289:29, 308:28, 342:6</p> <p>addiction [3] - 346:14,</p>	<p>346:18, 347:15</p> <p>additional [1] - 301:14</p> <p>address [7] - 264:26, 273:36, 285:32, 286:36, 313:30, 318:39, 355:11</p> <p>addressed [2] - 325:4, 353:8</p> <p>addressing [1] - 309:39</p> <p>adequacy [1] - 310:39</p> <p>ADHD [2] - 318:31, 324:43</p> <p>adhered [1] - 310:4</p> <p>adjourn [1] - 293:8</p> <p>ADJOURNED [1] - 365:45</p> <p>ADJOURNMENT [2] - 293:10, 321:21</p> <p>adjusted [1] - 275:2</p> <p>administers [1] - 281:28</p> <p>administrators [1] - 356:33</p> <p>admiration [1] - 356:2</p> <p>admission [3] - 289:40, 346:33, 364:19</p> <p>admissions [4] - 270:36, 270:45, 274:31, 274:40</p> <p>admitted [7] - 268:26, 268:34, 268:37, 269:30, 271:18, 281:8, 306:23</p> <p>adulthood [5] - 317:47, 324:45, 324:47, 348:36</p> <p>Adolescent [3] - 303:44, 306:8, 330:29</p> <p>adolescent [19] - 302:30, 302:31, 302:41, 306:30, 306:35, 307:16, 308:19, 312:38, 313:9, 314:24, 314:27, 314:31, 315:26, 317:37, 318:18, 318:19, 326:33, 327:22, 330:14</p> <p>adolescents [16] - 302:47, 305:41, 306:13, 307:28, 307:34, 308:28, 309:7, 309:43, 316:12, 316:23, 317:35, 318:43, 319:10, 319:45,</p>	<p>320:4, 347:4</p> <p>adopt [1] - 301:33</p> <p>adopted [1] - 328:45</p> <p>ads [2] - 335:26, 335:27</p> <p>adult [30] - 269:23, 269:36, 275:6, 292:2, 303:13, 303:21, 307:10, 307:11, 307:14, 307:20, 313:16, 325:1, 326:35, 328:32, 328:44, 329:24, 329:26, 329:33, 330:8, 330:18, 330:22, 330:28, 330:30, 331:19, 337:17, 346:1, 346:2, 356:12, 360:28, 365:1</p> <p>adult-centred [3] - 269:23, 269:36, 275:6</p> <p>adulthood [2] - 325:37, 329:13</p> <p>adults [10] - 268:47, 275:7, 292:4, 305:42, 306:47, 312:4, 319:29, 327:3, 347:5</p> <p>advance [4] - 321:5, 351:23, 354:31, 365:1</p> <p>advances [1] - 353:34</p> <p>advantage [1] - 348:20</p> <p>advantaged [1] - 293:36</p> <p>advent [1] - 341:44</p> <p>adverse [3] - 305:32, 312:9, 313:36</p> <p>advertisements [1] - 335:28</p> <p>advertising [3] - 335:19, 335:20, 335:22</p> <p>advice [4] - 294:13, 312:47, 314:42, 360:17</p> <p>advisory [3] - 348:39, 348:44, 361:46</p> <p>affected [2] - 328:5, 332:25</p> <p>affirmatively [1] - 333:25</p> <p>affirmed [4] - 264:43, 276:9, 293:15, 302:18</p> <p>afford [1] - 266:31</p>	<p>affordability [1] - 311:2</p> <p>AFTER [1] - 321:23</p> <p>afternoon [1] - 264:29</p> <p>afterwards [1] - 266:27</p> <p>age [43] - 265:5, 266:5, 269:38, 275:13, 303:3, 303:29, 303:38, 305:8, 306:16, 306:17, 306:22, 306:25, 307:22, 307:23, 315:22, 315:38, 316:13, 317:31, 317:42, 317:47, 318:2, 324:37, 324:38, 325:6, 325:9, 325:12, 326:3, 326:36, 329:13, 330:43, 331:18, 337:24, 345:30, 346:47, 347:43, 347:45, 348:3, 348:7, 348:26, 348:30, 349:31, 360:24, 360:37</p> <p>aged [9] - 300:43, 303:20, 305:6, 306:13, 313:23, 327:5, 347:5, 348:46</p> <p>ages [8] - 268:47, 307:4, 307:32, 308:10, 310:45, 316:17, 318:24, 363:47</p> <p>aggressive [1] - 346:5</p> <p>ago [5] - 329:45, 330:23, 331:34, 341:1, 349:35</p> <p>agree [7] - 309:27, 317:46, 324:38, 325:9, 341:1, 360:34, 361:26</p> <p>agrees [1] - 345:17</p> <p>ahead [5] - 285:42, 294:11, 297:19, 298:10, 323:3</p> <p>aimed [1] - 304:18</p> <p>aims [1] - 303:22</p> <p>alcohol [3] - 269:14, 269:16, 284:29</p> <p>Alex [1] - 263:28</p> <p>Alexander [1] - 351:21</p> <p>align [1] - 332:47</p> <p>aligned [4] - 303:12, 314:26, 314:27, 315:33</p> <p>alignment [1] - 312:17</p>	<p>Alison [1] - 337:47</p> <p>alive [3] - 273:22, 351:41, 352:27</p> <p>Allan [1] - 263:27</p> <p>allocated [2] - 356:40, 356:41</p> <p>allocation [2] - 316:3, 316:4</p> <p>allow [2] - 344:37, 345:21</p> <p>allowed [3] - 269:45, 270:25, 352:24</p> <p>allowing [1] - 344:14</p> <p>alluding [1] - 361:47</p> <p>almost [3] - 323:35, 341:20, 342:21</p> <p>alone [3] - 268:30, 270:6, 274:25</p> <p>alright [3] - 324:11, 339:39, 357:36</p> <p>alternative [1] - 300:4</p> <p>alternatives [1] - 360:19</p> <p>altogether [1] - 343:21</p> <p>amalgamate [2] - 288:11, 314:3</p> <p>amalgamated [1] - 317:25</p> <p>amassing [1] - 329:21</p> <p>ambience [1] - 346:31</p> <p>ambitious [1] - 323:9</p> <p>ambulance [3] - 267:31, 267:34, 267:35</p> <p>AMELIA [1] - 264:43</p> <p>Amelia [6] - 264:12, 264:41, 264:45, 275:41, 275:44, 275:47</p> <p>amount [6] - 287:38, 292:33, 299:37, 309:45, 342:24, 356:40</p> <p>amounts [1] - 341:13</p> <p>analogy [5] - 323:40, 333:35, 333:37, 335:18, 351:19</p> <p>analysis [1] - 299:41</p> <p>analysis [1] - 339:27</p> <p>anecdotal [1] - 349:46</p> <p>anomaly [2] - 345:11, 357:32</p> <p>answer [2] - 325:21, 339:21</p> <p>answered [1] - 344:26</p> <p>antenatal [1] - 281:30</p> <p>antenatally [1] - 281:30</p> <p>anti [1] - 266:2</p> <p>anti-anxiety [1] -</p>
---	--	--	---	--

<p>266:2 anticipate [1] - 323:6 anticipation [1] - 323:20 antidepressants [2] - 355:2, 355:3 anxiety [26] - 265:16, 265:42, 266:2, 275:22, 278:33, 280:40, 293:40, 294:40, 300:47, 305:38, 305:40, 307:45, 308:7, 308:9, 308:44, 318:30, 318:42, 319:10, 319:20, 324:37, 324:44, 332:16, 342:20, 363:47, 364:6, 364:21 Anxiety [1] - 280:1 anxiety/depressive [1] - 286:15 anxious [3] - 280:4, 287:42, 292:2 anyway [3] - 274:2, 274:37, 320:10 AO [1] - 263:27 apart [4] - 303:11, 307:2, 357:34, 359:11 appeared [1] - 352:5 applicable [2] - 337:13, 350:15 application [1] - 342:38 applied [1] - 305:15 applies [3] - 333:40, 350:47, 351:1 appointment [7] - 267:3, 270:36, 271:23, 274:2, 274:32, 285:12, 292:27 appointments [5] - 265:33, 273:47, 285:11, 291:13, 292:28 appreciate [2] - 309:17, 313:44 appreciation [1] - 305:11 approach [7] - 288:38, 295:27, 298:4, 298:38, 330:15, 330:16, 363:42 approached [1] - 314:20 approaches [3] - 264:7, 323:35,</p>	<p>329:43 appropriate [8] - 301:34, 301:44, 316:18, 317:32, 322:34, 330:16, 333:18, 356:37 approved [1] - 354:39 April [1] - 297:44 area [17] - 273:41, 275:21, 288:6, 289:27, 289:39, 294:25, 294:40, 303:8, 307:5, 313:30, 316:38, 319:38, 328:26, 329:3, 331:37, 337:12, 351:33 areas [23] - 281:47, 282:1, 285:32, 289:32, 297:4, 297:6, 304:23, 304:45, 307:13, 310:4, 314:15, 318:23, 322:30, 324:23, 333:40, 333:44, 333:46, 334:4, 351:26, 354:35, 355:36, 360:42, 361:10 arising [1] - 364:44 Armytage [1] - 263:26 arrangements [1] - 306:41 arrival [1] - 319:2 arrived [1] - 267:40 arriving [1] - 267:38 articulate [1] - 300:9 arts [2] - 299:18, 304:29 ashamed [1] - 280:7 aside [2] - 280:25, 287:33 aspects [4] - 276:30, 277:22, 278:19, 288:27 assault [1] - 284:25 assembled [1] - 343:34 assertive [2] - 364:28, 365:24 assessed [1] - 319:16 assessing [1] - 301:29 assessment [1] - 301:43 assignments [1] - 271:43 assist [2] - 286:17, 287:34 assistance [5] - 265:41, 276:12,</p>	<p>301:14, 321:31, 364:20 Assisting [1] - 263:33 associated [4] - 286:18, 318:43, 333:3, 347:35 association [1] - 348:16 Association [1] - 322:12 assume [1] - 319:40 assumed [2] - 329:1, 345:4 asylum [2] - 330:19, 344:35 asylums [1] - 359:43 AT [2] - 365:45, 365:46 atmosphere [1] - 297:24 attached [1] - 311:27 attempt [3] - 268:12, 307:15, 310:36 attempted [2] - 267:31, 344:21 attend [3] - 269:21, 280:45, 281:15 attendances [1] - 294:42 attention [9] - 265:17, 268:10, 272:8, 272:9, 305:7, 307:47, 315:21, 338:16, 347:46 attitudes [2] - 363:18, 363:20 attracted [1] - 338:15 attractive [1] - 358:25 attractiveness [1] - 342:7 attributes [1] - 336:15 audit [1] - 310:42 Auditor [1] - 310:42 Auditor-General's [1] - 310:42 August [1] - 270:17 Australia [11] - 317:6, 319:17, 326:28, 329:41, 340:30, 342:30, 349:28, 355:26, 355:28, 360:4, 360:6 Australia' [1] - 283:10 Australian [3] - 309:21, 322:8, 322:9 authorised [2] - 309:38, 358:18 authorising [1] - 359:18 authoritative [2] -</p>	<p>284:38, 284:39 autism [1] - 308:1 availability [3] - 320:3, 320:33, 321:2 available [18] - 267:47, 268:25, 282:17, 288:3, 289:7, 289:32, 312:27, 312:39, 314:15, 324:4, 334:24, 337:45, 340:5, 341:21, 343:31, 354:25, 355:5, 362:36 average [1] - 335:6 aware [9] - 300:2, 315:42, 319:32, 319:44, 320:36, 320:41, 349:1, 349:27, 357:19 awareness [5] - 279:18, 279:31, 280:11, 335:43 awful [4] - 269:10, 270:12, 270:15, 350:5</p>	<p>based [31] - 264:6, 296:45, 298:4, 299:18, 302:45, 303:41, 303:47, 311:15, 311:16, 311:18, 313:42, 314:9, 314:17, 314:30, 314:39, 314:47, 316:19, 320:24, 334:16, 339:36, 341:39, 343:38, 344:12, 347:9, 347:17, 351:6, 356:44, 358:7, 361:37, 364:26, 365:25 basic [3] - 302:28, 334:26, 361:24 basis [4] - 310:34, 311:9, 311:17, 341:30 Batten [1] - 263:35 beaten [1] - 328:2 beauty [2] - 323:2, 355:41 became [1] - 267:16 become [8] - 265:18, 289:24, 312:4, 317:44, 346:6, 352:32, 358:39 becomes [1] - 361:1 becoming [2] - 280:4, 287:41 bed [7] - 267:46, 268:11, 268:24, 269:1, 269:16, 357:7, 357:8 beds [8] - 268:46, 344:38, 345:40, 345:41, 346:1, 346:2, 357:26 began [2] - 270:17, 271:17 begin [2] - 278:42, 286:17 beginning [4] - 266:27, 326:2, 332:11, 341:33 behaviour [1] - 315:47 behavioural [3] - 287:23, 308:45, 342:38 behind [3] - 300:15, 325:25, 364:10 beings [1] - 286:38 Bell [1] - 351:21 below [1] - 360:45 benefit [6] - 280:26, 281:6, 323:15, 344:46, 353:43,</p>
B				
			<p>babies [1] - 284:45 baby [10] - 278:25, 279:37, 280:9, 280:18, 280:24, 280:25, 280:47, 281:1, 291:33, 346:14 Bachelor [4] - 276:20, 276:21, 302:28, 302:29 back-up [2] - 347:33, 348:15 background [3] - 293:37, 304:41, 358:3 backgrounds [4] - 284:11, 284:12, 285:3, 328:20 backs [1] - 352:45 bad [3] - 273:2, 273:3, 349:36 balance [1] - 323:13 balanced [1] - 364:17 ballpark [1] - 343:26 Banksia [1] - 306:29 bar [2] - 310:9, 343:3 barriers [4] - 343:36, 348:21, 348:22 base [2] - 292:5, 360:47</p>	

<p>362:25 benefits [2] - 319:28, 323:14 bent [2] - 334:12, 334:13 Bernadette [1] - 263:29 best [18] - 273:34, 285:35, 286:3, 290:1, 290:3, 294:9, 308:43, 308:47, 311:22, 317:40, 320:23, 324:4, 340:10, 340:21, 350:28, 355:41 better [36] - 266:25, 266:40, 267:26, 267:28, 271:19, 272:11, 272:22, 274:30, 275:2, 275:39, 295:38, 297:33, 313:17, 313:22, 313:38, 314:26, 314:28, 327:8, 328:28, 332:13, 332:27, 332:28, 333:9, 333:46, 334:10, 334:41, 336:35, 337:4, 339:31, 340:22, 350:5, 352:8, 352:16, 352:20, 353:41, 355:4 Better [1] - 310:14 between [31] - 268:46, 270:35, 270:44, 272:31, 273:6, 273:10, 273:26, 273:36, 274:31, 274:34, 274:38, 274:40, 283:18, 289:34, 300:10, 306:9, 306:19, 306:38, 306:40, 313:24, 315:12, 320:40, 324:38, 328:30, 330:43, 343:12, 354:7, 354:30, 355:22, 362:26, 364:30 Beyond [2] - 300:3, 364:6 beyond [8] - 294:14, 327:36, 328:15, 343:1, 356:4, 356:5, 361:2 big [14] - 267:10, 267:25, 268:46, 280:16, 281:17,</p>	<p>294:32, 298:43, 328:17, 335:3, 345:11, 345:25, 351:23, 354:6, 356:45 bigger [1] - 364:9 bigotry [3] - 350:8, 350:46, 363:37 biological [1] - 358:43 bipolar [2] - 283:45, 324:46 Birchwood [1] - 336:47 birthday [3] - 268:43, 269:8, 306:13 bit [32] - 266:16, 267:17, 267:44, 277:44, 288:23, 289:16, 290:19, 290:38, 292:9, 311:10, 312:21, 323:10, 324:40, 328:36, 331:8, 334:38, 342:16, 345:24, 345:45, 349:9, 351:22, 352:14, 353:20, 354:47, 357:23, 357:31, 358:1, 359:14, 360:18, 360:36, 363:21 blame [1] - 357:5 BLANKLEY [1] - 276:9 Blankley [3] - 264:13, 264:16, 276:6 blend [1] - 332:7 block [1] - 356:43 block-funded [1] - 356:43 blockages [1] - 290:24 blood [2] - 267:41, 282:44 Blue [2] - 300:3, 364:6 board [2] - 270:22, 339:43 Board [1] - 322:3 boards [1] - 362:3 body [3] - 277:32, 279:12, 322:41 bolted [1] - 306:46 book [1] - 269:3 booked [1] - 274:34 books [2] - 319:45, 319:47 borderline [1] - 364:2 boring [1] - 342:25 born [4] - 283:23, 286:38, 287:6, 305:33</p>	<p>borrowed [1] - 322:30 bothering [1] - 350:29 bottom [1] - 325:11 boundaries [2] - 328:43, 360:35 bracket [2] - 305:8, 316:13 brain [11] - 270:21, 286:47, 287:6, 287:11, 296:46, 318:1, 325:28, 325:30, 355:1 brain's [1] - 287:2 brains [1] - 286:39 branches [1] - 354:29 breadth [1] - 303:33 break [5] - 286:43, 292:10, 293:6, 321:16, 321:19 breakfast [1] - 268:5 breaks [1] - 296:46 breast [3] - 282:36, 282:37, 322:38 breastfeeding [3] - 279:9, 282:23, 282:38 brick [1] - 351:22 brief [5] - 283:9, 352:42, 363:17, 364:17, 364:30 briefly [5] - 276:29, 278:40, 283:8, 285:31, 287:46 bring [1] - 342:33 broad [4] - 298:23, 303:37, 306:1, 308:2 broader [5] - 334:46, 353:20, 355:8, 358:47, 359:1 brought [3] - 269:31, 274:17, 344:7 Bubs [1] - 304:22 budget [4] - 291:12, 355:19, 355:27, 358:6 build [4] - 297:3, 297:5, 298:9, 304:44 building [9] - 294:2, 297:8, 301:13, 304:29, 304:36, 312:18, 312:23, 312:27, 362:21 builds [1] - 299:19 built [6] - 334:17, 348:13, 348:15, 348:16, 351:27, 363:31 Burden [1] - 329:7 burden [6] - 266:31, 266:43, 267:10,</p>	<p>333:45, 355:21, 355:29 bus [1] - 335:28 Bush's [1] - 350:11 busy [1] - 289:9</p>	<p>304:45, 305:6, 312:18, 312:23, 312:27, 318:13, 334:16, 337:37, 346:35, 347:8 capita [1] - 310:34 cardiology [1] - 358:13 cardiovascular [3] - 334:31, 349:20, 353:30 care [188] - 264:14, 271:1, 272:30, 273:7, 273:26, 273:27, 273:36, 273:37, 275:5, 276:38, 277:11, 278:38, 279:23, 279:39, 280:11, 280:12, 280:14, 280:18, 280:20, 280:21, 280:28, 280:44, 280:47, 281:1, 281:9, 281:10, 281:11, 283:11, 284:39, 285:6, 285:16, 285:17, 285:21, 285:30, 285:31, 285:33, 286:5, 288:5, 288:28, 288:42, 289:5, 289:11, 289:14, 289:31, 289:38, 290:5, 290:20, 290:22, 290:23, 290:27, 290:34, 290:44, 290:45, 291:11, 291:39, 292:25, 292:35, 292:38, 302:46, 303:38, 303:41, 304:4, 304:43, 305:31, 306:9, 306:20, 306:23, 306:24, 306:26, 306:33, 306:39, 311:16, 312:17, 312:41, 313:12, 314:9, 314:18, 315:28, 315:33, 316:8, 320:3, 321:2, 322:21, 322:22, 322:23, 322:26, 322:29, 322:34, 323:3, 323:5, 323:22, 323:27, 323:41, 323:46, 324:12, 324:18, 324:23, 324:28, 324:29, 324:31,</p>
C				
<p>café [2] - 341:19, 346:34 CAHMS [1] - 317:21 calculation [1] - 343:25 CALD [2] - 328:25, 361:13 calming [1] - 346:34 CAMHS [36] - 302:38, 302:41, 302:45, 303:6, 303:7, 303:27, 304:15, 304:33, 305:5, 306:32, 306:45, 307:2, 307:3, 307:7, 309:28, 309:40, 309:43, 309:44, 310:2, 310:6, 310:33, 311:8, 311:9, 311:20, 311:29, 312:22, 314:3, 314:6, 314:13, 314:26, 315:5, 316:46, 317:26, 320:39, 320:40, 320:41 campaign [2] - 335:22, 335:25 Canada [1] - 314:32 cancer [21] - 314:19, 322:31, 322:38, 322:41, 323:40, 333:35, 333:36, 333:38, 333:45, 333:46, 334:32, 349:20, 351:26, 353:29, 354:3, 354:35, 355:36, 355:47, 356:1, 356:2 cancer's [1] - 333:47 cannot [4] - 287:6, 324:31, 343:3, 343:45 capable [4] - 331:41, 337:29, 337:31, 340:28 capacities [3] - 294:12, 295:7, 296:13 capacity [13] - 287:32, 299:14, 304:36,</p>	<p>304:45, 305:6, 312:18, 312:23, 312:27, 318:13, 334:16, 337:37, 346:35, 347:8 capita [1] - 310:34 cardiology [1] - 358:13 cardiovascular [3] - 334:31, 349:20, 353:30 care [188] - 264:14, 271:1, 272:30, 273:7, 273:26, 273:27, 273:36, 273:37, 275:5, 276:38, 277:11, 278:38, 279:23, 279:39, 280:11, 280:12, 280:14, 280:18, 280:20, 280:21, 280:28, 280:44, 280:47, 281:1, 281:9, 281:10, 281:11, 283:11, 284:39, 285:6, 285:16, 285:17, 285:21, 285:30, 285:31, 285:33, 286:5, 288:5, 288:28, 288:42, 289:5, 289:11, 289:14, 289:31, 289:38, 290:5, 290:20, 290:22, 290:23, 290:27, 290:34, 290:44, 290:45, 291:11, 291:39, 292:25, 292:35, 292:38, 302:46, 303:38, 303:41, 304:4, 304:43, 305:31, 306:9, 306:20, 306:23, 306:24, 306:26, 306:33, 306:39, 311:16, 312:17, 312:41, 313:12, 314:9, 314:18, 315:28, 315:33, 316:8, 320:3, 321:2, 322:21, 322:22, 322:23, 322:26, 322:29, 322:34, 323:3, 323:5, 323:22, 323:27, 323:41, 323:46, 324:12, 324:18, 324:23, 324:28, 324:29, 324:31,</p>			

<p>324:33, 327:37, 328:17, 328:27, 329:29, 331:27, 331:32, 331:43, 331:44, 332:14, 332:46, 333:17, 334:10, 335:36, 336:11, 336:15, 336:26, 339:6, 339:30, 339:35, 340:15, 340:16, 340:18, 340:24, 340:28, 340:33, 343:1, 343:24, 343:46, 344:1, 344:12, 345:8, 346:45, 347:20, 347:22, 347:30, 348:1, 348:2, 348:6, 348:7, 348:17, 348:21, 348:46, 351:26, 351:33, 351:36, 351:43, 353:17, 353:37, 354:29, 354:35, 355:19, 355:44, 356:6, 356:41, 357:3, 358:35, 358:38, 359:5, 359:8, 359:32, 359:44, 363:5, 364:18, 364:23, 364:26, 364:30, 364:31, 364:33, 364:34, 364:40, 364:42, 364:46, 365:5, 365:6, 365:9, 365:10, 365:12 career [2] - 297:30, 341:33 careful [1] - 336:32 carefully [1] - 336:34 caregiver [1] - 277:26 carers [1] - 323:22 cares [1] - 281:32 carried [2] - 335:3, 358:19 carrying [1] - 277:33 case [13] - 305:7, 307:13, 315:25, 317:4, 330:40, 330:42, 333:16, 334:26, 337:21, 347:6, 350:44, 354:39, 355:40 CASEA [2] - 304:15, 304:16 cases [5] - 315:8, 330:33, 331:3, 331:33, 344:13</p>	<p>cash [1] - 356:45 CAT [2] - 344:39, 344:40 catch [1] - 323:5 catch-up [1] - 323:5 catchment [9] - 303:8, 306:22, 307:5, 307:12, 310:4, 314:15, 318:23, 331:37, 351:32 caused [2] - 331:9, 349:18 causing [1] - 344:6 caveat [1] - 340:19 CBT [3] - 336:41, 341:44, 355:2 celebrating [1] - 338:12 cent [34] - 277:2, 289:23, 308:20, 308:27, 319:7, 324:47, 325:43, 325:47, 326:3, 326:37, 326:40, 326:42, 326:43, 326:44, 327:7, 330:33, 340:14, 340:21, 340:26, 340:32, 343:12, 343:22, 343:26, 355:19, 355:20, 355:27, 355:28, 355:32, 355:34, 361:21, 361:23, 365:4, 365:5 centre [2] - 314:46, 346:11 Centre [5] - 264:32, 314:34, 314:37, 321:47, 348:38 centred [6] - 269:23, 269:36, 275:6, 275:21, 288:38, 332:3 centres [4] - 347:27, 347:28, 348:13, 362:30 centric [1] - 359:4 Century [1] - 351:20 CEO [3] - 300:3, 353:25, 359:19 certain [4] - 309:11, 320:12, 323:28, 361:13 certainly [20] - 285:15, 297:12, 299:40, 303:35, 307:18, 309:19, 315:18, 315:25, 319:6, 319:12, 319:21,</p>	<p>319:23, 319:27, 319:31, 323:29, 323:36, 335:6, 338:11, 345:17, 349:30 chair [5] - 275:41, 291:1, 293:5, 299:22, 360:14 Chair [4] - 263:26, 264:1, 317:17, 321:9 CHAIR [18] - 275:44, 276:2, 291:4, 292:43, 293:1, 293:8, 299:25, 299:46, 300:40, 302:7, 302:11, 318:38, 321:7, 321:12, 321:19, 362:42, 364:14, 365:38 challenge [8] - 264:5, 298:38, 298:39, 306:44, 308:14, 319:4, 359:9, 361:5 challenges [13] - 282:21, 293:31, 294:4, 294:8, 294:10, 294:13, 294:14, 297:31, 298:10, 298:35, 299:10, 306:6, 325:34 challenging [3] - 298:32, 325:35, 325:40 chance [1] - 323:8 change [12] - 265:21, 273:5, 275:38, 278:9, 298:3, 299:39, 312:18, 318:10, 349:6, 359:15, 359:22, 360:3 changed [2] - 353:27, 355:10 changes [11] - 265:24, 278:15, 278:16, 278:23, 278:24, 278:28, 278:29, 278:30, 279:12, 286:9, 286:11 changing [3] - 325:26, 336:24, 355:40 character [1] - 296:43 characteristics [1] - 326:18 charge [2] - 346:18, 358:5 charged [1] - 269:45 charger [1] - 269:45</p>	<p>check [2] - 281:33, 292:7 checks [1] - 281:32 chemotherapy [1] - 322:40 Child [6] - 303:43, 306:8, 309:14, 312:29, 314:35, 330:29 child [45] - 276:41, 277:41, 283:13, 285:2, 292:19, 292:22, 292:25, 292:28, 292:31, 292:39, 302:30, 302:41, 304:22, 305:44, 306:35, 307:16, 308:7, 308:8, 308:18, 309:11, 310:8, 310:21, 310:22, 310:42, 312:38, 313:9, 314:23, 314:27, 314:30, 315:16, 315:25, 315:36, 316:11, 317:37, 318:18, 320:22, 326:33, 327:21, 328:38, 329:32, 330:12, 360:29 child's [4] - 294:2, 308:38, 308:41, 309:4 childbirth [1] - 280:2 childhood [9] - 284:21, 305:32, 307:45, 309:3, 312:9, 324:42, 325:37, 347:27 children [57] - 264:27, 269:26, 277:6, 285:5, 297:10, 300:46, 302:46, 304:4, 304:17, 304:40, 304:41, 304:42, 305:6, 305:22, 305:26, 305:31, 305:36, 305:41, 306:15, 307:28, 307:33, 308:20, 308:27, 308:35, 309:7, 309:17, 309:18, 309:42, 309:46, 310:6, 312:4, 312:12, 313:12, 313:18, 313:35, 313:45, 314:28, 315:1, 315:6,</p>	<p>315:37, 316:12, 316:23, 317:8, 317:35, 319:45, 320:4, 320:23, 320:45, 320:46, 321:4, 330:13, 345:40, 346:45 Children [1] - 313:42 children's [2] - 268:1, 314:19 Children's [14] - 264:23, 302:36, 303:11, 303:32, 303:34, 303:47, 304:40, 305:17, 305:47, 306:21, 306:41, 307:3, 312:25, 353:26 choice [1] - 279:13 choices [3] - 279:33, 279:34, 316:3 choosing [1] - 300:15 chose [1] - 300:11 Christine [1] - 353:25 Christoph [1] - 339:28 chronic [4] - 318:8, 322:32, 330:21, 337:7 chronological [1] - 360:37 cinema [2] - 335:26, 335:27 circumstances [1] - 296:15 cited [1] - 312:28 city [2] - 273:42, 345:38 City [3] - 294:23, 294:29, 295:23 clarification [2] - 360:23, 361:28 clarify [1] - 300:41 clarity [1] - 317:23 class [3] - 293:34, 296:8, 308:8 classic [1] - 332:47 classroom [2] - 299:1, 301:33 clay [1] - 335:13 clear [12] - 302:4, 306:39, 318:42, 320:35, 326:9, 327:21, 331:27, 332:18, 338:29, 339:15, 339:19, 345:17 clearer [1] - 320:16 clearly [4] - 291:29, 307:32, 307:36, 319:19</p>
--	---	--	--	---

<p>client [1] - 331:14 clientele [3] - 330:26, 330:34, 361:22 climb [1] - 349:32 clinic [2] - 320:47, 336:21 Clinical [2] - 276:16, 276:27 clinical [25] - 276:32, 281:39, 290:14, 303:36, 303:37, 304:44, 305:21, 305:22, 305:42, 319:31, 323:17, 323:28, 332:44, 336:11, 336:15, 336:26, 338:2, 338:5, 341:1, 341:19, 341:20, 357:43, 358:2, 358:3, 358:12 clinically [1] - 290:14 clinician [3] - 276:32, 281:11, 289:25 clinicians [2] - 290:3, 290:6 clinics [8] - 276:33, 281:30, 303:42, 303:46, 330:13, 347:35, 357:27, 364:38 clock [5] - 344:18, 347:8, 347:9, 347:10 close [2] - 275:12, 308:20 closed [2] - 319:45, 363:12 closing [1] - 319:47 clothes [1] - 269:4 clozapine [1] - 336:35 CO [2] - 357:1, 357:8 co [1] - 317:6 co-located [1] - 317:6 coaching [1] - 296:45 Coca [1] - 335:20 Coca-Cola [1] - 335:20 Cochrane [1] - 337:43 COCKRAM [5] - 300:1, 317:20, 318:36, 361:30, 362:40 Cockram [3] - 263:28, 299:46, 362:46 Coghlan [1] - 263:36 COGLAN [19] - 264:1, 264:45, 275:41, 275:47, 276:6, 276:11, 291:1, 292:45,</p>	<p>293:5, 293:12, 293:17, 299:22, 300:38, 302:9, 302:15, 302:20, 317:17, 321:9, 321:16 cognitive [2] - 342:22, 342:38 coherence [1] - 306:38 cohorts [2] - 351:15, 360:24 Cola [1] - 335:20 collaboration [3] - 304:36, 311:24, 320:40 collaborations [4] - 303:36, 304:21, 304:31, 304:43 collaborative [1] - 304:10 collaboratively [1] - 296:27 collapsed [1] - 357:13 colleagues [3] - 300:46, 339:29, 354:29 collected [1] - 294:37 collecting [1] - 299:41 collective [1] - 295:3 college [1] - 329:41 Collingwood [1] - 361:23 combined [1] - 335:33 comfortable [3] - 264:45, 326:21, 348:37 coming [11] - 267:24, 271:32, 274:35, 278:20, 287:7, 287:10, 294:31, 320:47, 321:1, 330:12, 351:15 commenced [1] - 340:3 COMMISSION [2] - 263:5, 365:45 Commission [17] - 264:6, 264:47, 276:12, 293:18, 302:23, 303:16, 321:31, 322:21, 327:47, 348:45, 350:39, 355:16, 355:42, 359:18, 359:31, 359:34, 365:15 commissioned [1] - 294:28 COMMISSIONER [10]</p>	<p>- 299:27, 300:1, 317:20, 318:36, 360:16, 361:28, 361:30, 362:40, 362:44, 364:12 Commissioners [13] - 264:1, 265:12, 275:42, 291:2, 299:23, 302:39, 316:30, 317:18, 321:25, 325:17, 336:13, 360:14, 365:43 commissions [1] - 359:27 commitment [1] - 312:27 common [4] - 314:17, 317:44, 348:29, 355:31 Commonwealth [1] - 310:13 communicable [1] - 353:23 communication [4] - 270:45, 274:33, 274:37, 306:39 communities [3] - 328:25, 359:7, 361:13 community [59] - 276:41, 278:44, 280:10, 280:29, 280:46, 283:41, 286:4, 286:27, 289:5, 290:44, 292:4, 303:41, 305:10, 306:10, 306:11, 306:24, 306:30, 313:22, 313:33, 315:32, 316:7, 317:5, 317:33, 320:14, 335:15, 336:21, 338:22, 344:12, 344:36, 345:5, 345:9, 345:14, 346:40, 346:42, 347:31, 351:6, 352:21, 352:24, 352:31, 353:15, 353:16, 357:10, 357:13, 357:26, 357:27, 357:32, 358:32, 359:17, 359:21, 361:18, 361:37, 362:9, 362:25, 362:27, 362:30, 362:38, 364:38, 365:24</p>	<p>community" [2] - 313:39, 364:28 community-based [3] - 344:12, 351:6, 361:37 community-led [1] - 361:18 comorbid [1] - 265:16 comorbidities [1] - 332:8 comorbidity [2] - 329:20, 346:24 compare [3] - 326:26, 327:3, 349:26 compared [3] - 340:15, 340:23, 353:22 comparison [1] - 340:16 compelling [1] - 309:13 competed [1] - 270:42 complete [2] - 325:30, 336:42 completed [3] - 299:33, 338:35, 344:21 completely [4] - 317:46, 330:25, 346:31 complex [4] - 291:9, 303:1, 328:16, 344:13 Complex [1] - 307:21 complexity [2] - 291:6, 332:26 complicates [1] - 287:43 component [6] - 276:43, 290:38, 290:44, 290:45, 336:24, 362:7 comprehensive [1] - 336:26 comprised [1] - 334:38 comprises [1] - 294:21 conceived [1] - 317:42 concentrate [1] - 280:24 concentrated [1] - 301:4 concept [5] - 322:29, 347:30, 350:18, 363:31, 364:27 conception [2] - 283:26, 285:30 conceptual [1] - 317:36</p>	<p>concerned [1] - 301:12 concerning [1] - 301:21 concerns [1] - 340:47 concert [1] - 348:30 concluded [2] - 340:13, 340:39 concludes [1] - 365:42 conclusions [2] - 337:36, 338:23 condition [5] - 324:30, 324:32, 337:32, 352:9, 352:11 conditions [13] - 278:13, 303:39, 307:44, 308:2, 308:11, 320:12, 320:17, 322:33, 330:22, 340:29, 342:14, 342:19, 346:17 conduct [5] - 304:18, 304:19, 307:46, 308:46, 309:15 conducted [2] - 309:14, 309:15 cone [1] - 308:25 conference [1] - 334:42 confident [1] - 360:10 confined [1] - 341:29 conflict [1] - 319:11 confused [1] - 332:33 congenital [1] - 305:25 Congress [1] - 339:33 conjunction [3] - 276:35, 294:29, 301:25 connections [1] - 287:3 conscious [1] - 319:27 consciousness [1] - 267:44 consent [1] - 318:14 consequences [1] - 358:15 consider [5] - 264:7, 279:6, 285:30, 286:35, 307:26 considerably [1] - 324:32 considered [7] - 277:19, 277:46, 280:29, 281:10, 281:17, 282:40, 282:42</p>
---	--	---	---	---

<p>consigned [1] - 358:39</p> <p>consistency [2] - 314:8, 314:18</p> <p>consistent [1] - 317:39</p> <p>constant [2] - 351:26, 351:27</p> <p>constrained [1] - 363:14</p> <p>consultant [1] - 302:31</p> <p>consultation [3] - 301:32, 312:31, 312:39</p> <p>consumer [2] - 264:13, 350:18</p> <p>consumers [4] - 320:44, 353:42, 364:21, 365:14</p> <p>contact [4] - 270:44, 274:30, 274:41, 312:43</p> <p>contacted [1] - 268:32</p> <p>contemporaneous [1] - 319:2</p> <p>contend [1] - 318:13</p> <p>content [1] - 358:7</p> <p>content-based [1] - 358:7</p> <p>contested [2] - 317:22, 317:36</p> <p>context [11] - 264:25, 280:34, 288:32, 306:1, 308:28, 310:39, 319:35, 323:21, 336:31, 342:45, 357:24</p> <p>continue [2] - 316:14, 361:31</p> <p>continues [1] - 309:14</p> <p>continuing [4] - 264:2, 297:28, 316:13, 363:5</p> <p>continuity [3] - 323:22, 323:24, 345:8</p> <p>continuum [1] - 301:2</p> <p>contracts [1] - 359:23</p> <p>contrast [4] - 308:45, 324:27, 349:19, 352:40</p> <p>contrasted [1] - 353:29</p> <p>contribute [1] - 327:31</p> <p>contributed [1] - 269:39</p> <p>contributing [1] - 350:40</p>	<p>control [2] - 270:1, 358:10</p> <p>convenient [2] - 293:5, 321:16</p> <p>conventional [2] - 323:36, 328:43</p> <p>conveying [1] - 313:11</p> <p>coordinating [1] - 276:34</p> <p>cope [1] - 344:37</p> <p>copy [1] - 321:39</p> <p>corners [1] - 344:32</p> <p>correct [10] - 284:19, 293:23, 296:31, 297:38, 301:45, 303:14, 305:2, 305:3, 323:41, 324:11</p> <p>Correll [1] - 339:28</p> <p>cortex [1] - 287:5</p> <p>cost [10] - 285:17, 285:18, 289:13, 291:9, 291:10, 311:47, 356:3, 356:8, 356:18, 359:32</p> <p>cost-effectiveness [3] - 311:47, 356:8, 356:18</p> <p>cost-ineffective [1] - 356:3</p> <p>costs [1] - 290:5</p> <p>council [1] - 353:46</p> <p>Council [3] - 294:23, 294:29, 295:23</p> <p>Counsel [1] - 263:33</p> <p>counsellors [2] - 310:24, 326:46</p> <p>countries [3] - 328:40, 342:34, 360:3</p> <p>country [2] - 265:9, 336:3</p> <p>couple [15] - 269:6, 269:15, 269:46, 270:33, 270:39, 281:35, 298:28, 304:34, 336:28, 337:36, 339:26, 345:3, 347:41, 356:27, 360:28</p> <p>course [17] - 266:2, 274:29, 275:1, 275:22, 278:9, 301:43, 306:34, 310:23, 312:5, 318:1, 323:7, 325:24, 332:39, 337:19, 346:32, 348:36, 349:5</p>	<p>cover [5] - 303:29, 328:41, 329:36, 336:11, 355:34</p> <p>covered [3] - 326:35, 335:29, 336:12</p> <p>covering [4] - 315:6, 343:11, 352:44, 355:32</p> <p>cow [1] - 356:45</p> <p>create [9] - 297:23, 297:33, 329:46, 331:35, 333:17, 333:31, 344:27, 348:2, 359:39</p> <p>created [2] - 330:18, 340:44</p> <p>creates [1] - 325:42</p> <p>creating [2] - 359:41, 359:44</p> <p>creative [2] - 315:39, 342:40</p> <p>credibility [1] - 358:4</p> <p>crises [2] - 291:15, 291:30</p> <p>crisis [6] - 280:29, 280:34, 280:35, 291:16, 291:18, 344:3</p> <p>criteria [4] - 310:5, 326:4, 330:8, 338:1</p> <p>critical [5] - 264:37, 314:16, 336:46, 357:37, 364:47</p> <p>criticised [1] - 318:4</p> <p>crossed [1] - 283:23</p> <p>crossover [1] - 296:23</p> <p>crucial [2] - 335:13, 345:21</p> <p>cube [1] - 307:31</p> <p>cultural [3] - 299:38, 348:31, 353:8</p> <p>culturally [2] - 284:10, 328:19</p> <p>Culturally [1] - 284:12</p> <p>culture [6] - 295:33, 297:23, 331:27, 340:44, 353:37, 361:25</p> <p>cultures [2] - 346:45, 359:44</p> <p>cupboard [1] - 269:2</p> <p>cure [2] - 323:8, 338:10</p> <p>cured [1] - 333:47</p> <p>current [14] - 264:24, 265:44, 276:27, 289:30, 302:34, 349:8, 353:25, 356:31, 357:20, 357:23, 358:27,</p>	<p>360:20, 364:17, 364:37</p> <p>curriculum [3] - 296:16, 297:5, 299:2</p> <p>curtain [1] - 269:1</p> <p>curtains [1] - 268:46</p> <p>curve [2] - 334:13</p> <p>custody [1] - 344:9</p> <p>cut [4] - 274:42, 274:46, 289:19, 328:34</p> <p>cut-off [1] - 328:34</p> <p>cutoffs [1] - 306:22</p> <p>CV [1] - 322:17</p> <p>cyberbullying [1] - 319:33</p> <p>cycle [1] - 267:17</p> <p>cycled [1] - 270:10</p> <p>CYMHS [11] - 303:16, 303:17, 303:27, 306:32, 312:22, 315:6, 315:8, 316:46, 320:39, 320:40, 320:41</p>	<p>354:15</p> <p>dealing [2] - 312:31, 341:32</p> <p>deaths [1] - 350:16</p> <p>debate [6] - 332:44, 338:23, 338:25, 338:27, 348:44, 355:27</p> <p>debates [1] - 338:36</p> <p>decade [1] - 348:40</p> <p>decades [1] - 349:23</p> <p>decision [1] - 300:22</p> <p>decline [2] - 327:45, 330:25</p> <p>declined [1] - 318:45</p> <p>declining [1] - 333:23</p> <p>decrease [1] - 279:41</p> <p>dedicated [2] - 295:24, 304:35</p> <p>deemed [1] - 360:37</p> <p>defend [1] - 359:46</p> <p>deficit [2] - 265:17, 307:47</p> <p>define [2] - 332:37, 332:38</p> <p>defined [1] - 332:32</p> <p>definitely [8] - 269:43, 275:38, 290:5, 327:28, 333:31, 355:47, 358:22, 362:3</p> <p>definitive [3] - 306:35, 325:22, 349:2</p> <p>degree [4] - 302:28, 308:23, 308:44, 309:6</p> <p>degrees [3] - 303:28, 307:35, 308:6</p> <p>delay [5] - 335:47, 337:37, 338:11, 338:14, 354:30</p> <p>delayed [1] - 338:7</p> <p>deliberate [1] - 330:39</p> <p>deliberately [1] - 363:27</p> <p>deliver [8] - 290:46, 296:5, 296:30, 299:3, 302:46, 320:34, 322:34, 334:27</p> <p>delivered [5] - 296:2, 299:7, 303:44, 320:23, 323:35</p> <p>delivering [1] - 354:24</p> <p>delivers [3] - 334:18, 334:25, 334:26</p> <p>delivery [3] - 276:32, 289:46, 307:9</p> <p>demand [2] - 309:38, 309:39</p>
D				
			<p>dad [1] - 274:22</p> <p>danger [1] - 273:15</p> <p>DANIEL [1] - 293:15</p> <p>data [29] - 280:36, 287:46, 288:3, 288:8, 288:9, 288:17, 288:21, 288:23, 288:34, 293:35, 294:31, 294:35, 294:37, 299:34, 299:37, 299:41, 301:7, 319:19, 320:35, 328:22, 329:8, 337:21, 338:28, 338:36, 340:5, 340:10</p> <p>dates [1] - 271:42</p> <p>days [14] - 268:24, 268:27, 268:33, 269:11, 269:15, 276:31, 327:47, 328:2, 335:27, 336:33, 341:38, 341:44, 352:3, 364:34</p> <p>dead [1] - 344:4</p> <p>deal [10] - 271:44, 274:20, 274:24, 320:37, 320:38, 340:36, 342:21, 342:23, 352:4,</p>	

<p>demographics [1] - 296:25</p> <p>demonstrated [1] - 310:41</p> <p>DENNISTON [1] - 321:28</p> <p>Department [7] - 294:23, 295:24, 300:5, 332:33, 357:5, 357:6, 357:19</p> <p>department [11] - 267:40, 301:27, 302:35, 304:6, 315:43, 316:6, 319:8, 344:8, 346:28, 350:29, 350:32</p> <p>departments [3] - 344:14, 344:20, 353:17</p> <p>dependent [5] - 277:25, 277:29, 286:45, 291:43, 309:5</p> <p>depict [1] - 360:27</p> <p>depressed [5] - 280:4, 287:19, 287:42, 292:2, 350:36</p> <p>depression [22] - 278:33, 280:40, 287:24, 293:40, 294:41, 300:47, 305:38, 305:41, 307:45, 308:44, 318:31, 318:33, 318:42, 319:10, 319:20, 324:37, 324:45, 332:16, 354:43, 359:28, 363:47, 364:6</p> <p>Depression [1] - 280:1</p> <p>depressive [1] - 265:15</p> <p>Deputy [2] - 276:16, 276:27</p> <p>describe [3] - 267:38, 287:37, 300:42</p> <p>described [7] - 270:29, 288:42, 300:47, 308:14, 323:33, 346:43, 348:17</p> <p>describing [3] - 300:9, 317:27, 317:33</p> <p>description [1] - 317:26</p> <p>descriptive [1] - 340:4</p> <p>design [18] - 311:32, 313:10, 314:7,</p>	<p>317:35, 317:39, 331:5, 331:9, 331:16, 331:19, 332:3, 344:46, 346:37, 353:47, 357:18, 359:39, 361:37, 361:45, 362:26</p> <p>designed [8] - 306:47, 308:34, 313:13, 341:2, 343:38, 344:34, 346:43, 355:9</p> <p>designing [3] - 329:27, 331:46, 361:8</p> <p>desire [1] - 265:46</p> <p>desperate [1] - 352:27</p> <p>destabilised [1] - 357:10</p> <p>destigmatise [1] - 333:29</p> <p>destigmatising [1] - 364:1</p> <p>detail [1] - 344:31</p> <p>detection [3] - 334:39, 334:41, 336:10</p> <p>deteriorating [2] - 334:9, 340:27</p> <p>determine [1] - 340:21</p> <p>deterministic [1] - 333:39</p> <p>detoxification [2] - 346:15, 346:17</p> <p>devastating [2] - 349:44, 350:4</p> <p>develop [11] - 283:29, 283:34, 295:33, 296:15, 297:5, 300:32, 305:40, 311:28, 311:39, 325:44, 332:22</p> <p>developed [12] - 294:33, 296:40, 297:1, 323:18, 328:37, 334:21, 334:24, 336:38, 342:14, 354:7, 354:8, 361:41</p> <p>developing [12] - 277:29, 294:11, 295:6, 295:32, 296:13, 296:42, 308:15, 314:42, 314:43, 325:28, 325:38, 334:44</p> <p>development [18] - 277:28, 277:35, 282:31, 282:35, 286:46, 287:15,</p>	<p>287:23, 292:16, 297:3, 300:25, 314:8, 318:1, 325:26, 328:38, 332:24, 337:31, 341:34</p> <p>developmental [7] - 304:40, 317:34, 320:47, 325:33, 325:36, 330:15, 348:35</p> <p>developmentally [1] - 360:38</p> <p>developments [1] - 294:36</p> <p>develops [1] - 287:11</p> <p>devis [1] - 307:38</p> <p>devised [1] - 307:14</p> <p>devising [1] - 307:36</p> <p>devolved [4] - 307:6, 311:29, 314:5, 317:38</p> <p>devoted [1] - 316:7</p> <p>devotion [1] - 312:26</p> <p>diabetes [2] - 338:13, 338:15</p> <p>diabetic [1] - 273:10</p> <p>diagnosable [3] - 326:4, 326:8, 326:45</p> <p>diagnose [2] - 323:42, 334:6</p> <p>diagnosed [3] - 265:15, 265:42, 335:5</p> <p>diagnoses [1] - 333:1</p> <p>diagnosis [10] - 265:43, 265:44, 322:33, 322:46, 323:47, 332:26, 333:19, 333:34, 336:12, 336:29</p> <p>diagnostic [1] - 281:39</p> <p>diagram [4] - 344:27, 344:28, 344:32, 346:12</p> <p>die [1] - 349:40</p> <p>died [4] - 274:40, 331:1, 349:43, 350:1</p> <p>differ [1] - 310:28</p> <p>difference [2] - 270:24, 275:36</p> <p>differences [3] - 300:10, 348:28, 354:6</p> <p>different [62] - 265:43, 268:17, 268:47, 270:11, 275:17, 278:7, 278:26, 284:35, 284:36,</p>	<p>284:42, 288:27, 291:17, 291:18, 296:21, 296:26, 296:38, 297:4, 299:9, 300:6, 300:8, 300:33, 301:28, 307:34, 307:35, 307:37, 307:39, 310:28, 318:7, 318:12, 322:27, 323:3, 323:31, 328:33, 328:47, 330:26, 330:35, 331:19, 332:17, 332:34, 334:20, 335:27, 339:31, 340:24, 341:45, 344:32, 346:31, 346:32, 346:45, 346:46, 347:3, 347:16, 348:3, 348:27, 348:35, 351:12, 351:16, 355:3, 355:43, 360:38, 361:25</p> <p>differently [1] - 298:38</p> <p>differing [1] - 303:28</p> <p>difficult [24] - 266:45, 266:46, 267:8, 271:12, 272:16, 272:20, 273:41, 274:25, 275:7, 281:8, 281:16, 284:37, 285:13, 285:16, 288:6, 288:25, 289:37, 289:40, 289:41, 289:42, 291:8, 311:4, 321:1, 335:11</p> <p>difficulties [24] - 264:26, 303:24, 305:35, 307:47, 308:33, 308:36, 308:46, 309:19, 309:44, 309:47, 311:40, 312:9, 312:10, 312:32, 313:37, 313:45, 316:41, 316:42, 318:8, 318:30, 319:11, 319:34, 320:27, 355:13</p> <p>difficulty [4] - 308:7, 309:24, 326:15, 326:17</p> <p>dilution [1] - 282:46</p> <p>dimension [2] - 308:5, 363:19</p> <p>dimensions [4] - 307:27, 307:30,</p>	<p>307:40, 308:14</p> <p>direct [1] - 312:30</p> <p>directed [1] - 307:19</p> <p>direction [2] - 337:9, 362:4</p> <p>Director [8] - 264:23, 264:31, 276:16, 276:28, 302:35, 321:46, 322:3, 334:12</p> <p>directors [1] - 353:4</p> <p>disabilities [2] - 304:41, 320:47</p> <p>disagree [1] - 325:11</p> <p>disappointing [1] - 352:17</p> <p>discharge [3] - 271:1, 274:42, 274:44</p> <p>discharged [8] - 268:25, 270:26, 270:32, 270:47, 271:8, 274:45, 352:10, 364:37</p> <p>discipline [1] - 316:38</p> <p>disciplines [3] - 302:46, 305:45, 347:16</p> <p>disclosed [1] - 266:38</p> <p>discontinuity [1] - 330:43</p> <p>discourse [1] - 332:31</p> <p>discovery [1] - 334:34</p> <p>discrete [1] - 299:7</p> <p>discriminated [1] - 354:16</p> <p>discrimination [1] - 354:9</p> <p>discuss [4] - 286:2, 288:6, 298:37, 337:36</p> <p>discussion [1] - 327:38</p> <p>Disease [1] - 329:8</p> <p>disease [3] - 333:45, 349:21, 355:21</p> <p>diseases [1] - 353:23</p> <p>disengaged [1] - 269:34</p> <p>disengagement [1] - 327:31</p> <p>disincentives [1] - 320:20</p> <p>dismissed [5] - 265:24, 268:6, 268:15, 272:43, 272:44</p> <p>disorder [20] - 265:16, 265:17, 278:7, 278:33, 280:17, 280:20, 285:34,</p>
---	--	--	--	--

<p>286:19, 307:47, 308:1, 308:21, 324:46, 326:5, 326:8, 326:44, 326:45, 329:3, 332:26, 337:24</p> <p>disorders [44] - 279:5, 280:38, 280:40, 283:46, 283:47, 284:30, 284:33, 286:24, 292:23, 303:1, 304:2, 304:7, 304:19, 306:36, 307:11, 307:44, 307:46, 308:15, 308:32, 311:36, 311:38, 313:23, 316:24, 317:43, 318:8, 318:15, 319:16, 324:41, 324:43, 324:46, 325:1, 326:9, 326:10, 328:3, 332:23, 334:45, 337:13, 337:17, 337:18, 337:19, 337:26, 349:1</p> <p>disorders" [1] - 326:12</p> <p>disposal [1] - 334:28</p> <p>disseminating [1] - 314:38</p> <p>distress [1] - 333:1</p> <p>distressing [4] - 267:42, 272:19, 274:14, 321:2</p> <p>disturbance [1] - 344:6</p> <p>disturbing [1] - 269:7</p> <p>diverse [3] - 284:10, 284:12, 328:20</p> <p>diversity [1] - 300:28</p> <p>divert [1] - 357:2</p> <p>diverted [1] - 357:14</p> <p>divide [1] - 343:7</p> <p>divided [1] - 345:29</p> <p>dividing [2] - 325:12, 360:24</p> <p>division [1] - 325:13</p> <p>doctor [10] - 266:5, 268:17, 276:11, 278:19, 285:44, 291:1, 292:45, 316:28, 317:14, 321:9</p> <p>doctors [2] - 276:36, 276:38</p> <p>dog [3] - 267:32, 269:9, 359:5</p> <p>dollars [2] - 354:38,</p>	<p>364:5</p> <p>domains [1] - 347:14</p> <p>done [28] - 267:41, 271:25, 275:16, 281:29, 281:32, 281:35, 294:29, 300:18, 313:15, 316:5, 323:27, 323:41, 331:44, 334:1, 338:30, 338:33, 338:46, 340:2, 340:7, 343:15, 351:25, 351:26, 352:23, 356:18, 358:21, 359:41, 361:47</p> <p>dose [1] - 336:34</p> <p>down [14] - 267:33, 270:14, 286:43, 287:23, 288:7, 289:44, 292:41, 300:22, 329:33, 336:1, 353:3, 360:44</p> <p>downplayed [1] - 272:46</p> <p>Dr [15] - 263:28, 264:13, 264:16, 264:22, 276:6, 299:46, 302:15, 302:20, 317:20, 318:38, 324:42, 325:10, 331:31, 347:47, 362:46</p> <p>dramatic [3] - 268:9, 325:29, 344:37</p> <p>dramatically [4] - 325:26, 340:39, 342:1, 344:18</p> <p>drawn [1] - 333:35</p> <p>drive [5] - 266:47, 267:2, 267:4, 267:5, 356:38</p> <p>driven [1] - 347:38</p> <p>drivers [1] - 294:32</p> <p>drug [6] - 269:13, 269:15, 313:25, 334:22, 336:35, 354:35</p> <p>DSM [1] - 332:47</p> <p>dual [1] - 358:2</p> <p>due [4] - 271:42, 271:45, 326:18, 326:19</p> <p>dumped [1] - 330:23</p> <p>duration [1] - 278:46</p> <p>during [13] - 270:9, 278:9, 278:11, 280:4, 282:22, 298:33, 325:29, 325:44, 326:2,</p>	<p>326:5, 347:13, 347:14</p> <p>dying [1] - 349:29</p> <p>dynamic [1] - 347:7</p> <p style="text-align: center;">E</p> <p>earliest [3] - 323:42, 332:44, 332:46</p> <p>early [59] - 264:2, 264:7, 274:2, 278:44, 278:46, 279:2, 279:3, 283:34, 286:7, 286:13, 286:17, 286:22, 287:17, 287:25, 305:25, 311:33, 311:45, 312:1, 312:4, 312:12, 313:27, 318:2, 322:38, 324:45, 325:27, 329:10, 329:19, 330:28, 332:30, 332:35, 332:38, 333:34, 334:6, 334:38, 334:39, 334:41, 334:44, 335:17, 335:31, 336:9, 336:10, 336:35, 336:46, 337:16, 337:29, 337:30, 337:47, 338:40, 339:16, 340:4, 341:10, 347:27, 348:36, 355:10, 356:19, 363:28</p> <p>Early [1] - 332:37</p> <p>easier [2] - 271:44, 287:5</p> <p>easily [3] - 287:35, 312:12, 357:14</p> <p>easy [1] - 266:44</p> <p>eating [4] - 304:2, 307:45, 332:23, 337:18</p> <p>Economic [1] - 359:23</p> <p>economic [3] - 310:30, 312:3, 355:39</p> <p>EDs [1] - 319:1</p> <p>educating [4] - 297:20, 301:44, 335:16, 335:30</p> <p>education [13] - 279:18, 279:28, 279:29, 279:32, 279:39, 279:41, 280:10, 280:14,</p>	<p>280:30, 296:1, 297:31, 335:16, 342:2</p> <p>Education [26] - 264:19, 294:19, 294:23, 294:47, 295:1, 295:10, 295:18, 295:20, 295:22, 295:24, 295:25, 295:27, 296:4, 296:7, 296:18, 296:37, 297:12, 297:37, 298:19, 298:22, 298:44, 300:5, 300:12, 300:15, 300:17, 300:31</p> <p>educational [3] - 290:43, 295:15, 348:17</p> <p>educators [6] - 294:10, 294:16, 301:16, 308:47, 313:46</p> <p>effect [4] - 282:46, 288:13, 311:38</p> <p>effective [9] - 264:9, 285:38, 311:20, 311:43, 334:28, 342:27, 346:38, 348:10, 357:40</p> <p>effectively [4] - 266:17, 281:45, 334:18, 356:21</p> <p>effectiveness [4] - 288:4, 311:47, 356:8, 356:18</p> <p>effects [1] - 270:12</p> <p>efficient [1] - 353:2</p> <p>efficiently [1] - 352:37</p> <p>effort [6] - 299:44, 329:46, 331:24, 341:34, 364:9, 365:30</p> <p>effort's [1] - 364:1</p> <p>efforts [2] - 324:3, 354:34</p> <p>eight [3] - 303:8, 349:42, 364:34</p> <p>either [15] - 277:4, 277:16, 277:27, 277:31, 278:2, 278:25, 284:38, 298:1, 306:24, 329:34, 330:8, 340:26, 346:33, 348:15, 360:34</p> <p>elaborate [4] - 307:29, 329:6, 349:7, 357:46</p> <p>elderly [2] - 348:43,</p>	<p>349:1</p> <p>element [1] - 346:19</p> <p>elements [10] - 264:36, 334:32, 335:25, 335:46, 339:8, 344:30, 345:38, 346:25, 357:37, 361:24</p> <p>Elevit [1] - 285:45</p> <p>elsewhere [1] - 350:10</p> <p>embarking [1] - 359:28</p> <p>embedded [2] - 289:27, 347:19</p> <p>embodied [3] - 322:28, 324:16, 344:25</p> <p>embrace [1] - 342:17</p> <p>embraced [3] - 345:15, 350:18, 354:2</p> <p>emerged [2] - 325:1, 332:42</p> <p>emergency [18] - 266:33, 266:36, 267:40, 272:31, 273:7, 273:26, 273:37, 304:5, 310:6, 316:6, 319:8, 344:8, 344:14, 344:20, 346:27, 350:29, 350:32, 353:17</p> <p>emerging [1] - 347:5</p> <p>emotional [1] - 319:11</p> <p>emotionally [1] - 298:35</p> <p>emotions [3] - 296:12, 296:43, 298:44</p> <p>emphasis [2] - 318:23, 318:24</p> <p>employed [1] - 314:45</p> <p>employment [1] - 342:2</p> <p>empowered [2] - 357:43, 359:21</p> <p>empowering [1] - 359:21</p> <p>enable [3] - 273:22, 273:33, 273:35</p> <p>encompass [1] - 329:33</p> <p>encounter [2] - 294:3, 328:21</p> <p>encountered [1] - 272:6</p> <p>encouraging [1] - 337:25</p> <p>end [13] - 266:23, 266:30, 270:23,</p>
--	---	---	---	---

<p>288:10, 294:38, 304:26, 310:47, 325:11, 327:41, 337:7, 344:7, 348:27, 352:41</p> <p>ended [8] - 266:33, 267:7, 267:31, 267:47, 268:16, 268:19, 269:19, 288:10</p> <p>enduring [2] - 309:18, 351:14</p> <p>engage [1] - 340:45</p> <p>engaged [3] - 326:22, 348:45, 350:41</p> <p>engagement [5] - 296:43, 328:25, 340:40, 340:43, 361:40</p> <p>English [1] - 293:37</p> <p>enhance [1] - 297:24</p> <p>enhanced [3] - 339:5, 340:35, 348:7</p> <p>enjoyed [1] - 265:19</p> <p>enjoying [1] - 280:8</p> <p>enormous [7] - 280:15, 287:38, 292:33, 305:27, 308:27, 321:5, 352:26</p> <p>ensue [1] - 311:12</p> <p>entire [1] - 326:9</p> <p>entirely [2] - 298:7, 315:24</p> <p>entry [1] - 341:20</p> <p>environment [12] - 277:30, 277:31, 277:33, 290:21, 297:33, 305:36, 325:33, 346:47, 354:14, 359:18, 362:8</p> <p>envisaged [1] - 351:5</p> <p>envy [1] - 356:1</p> <p>Epic [1] - 364:45</p> <p>epidemiological [1] - 319:19</p> <p>episode [8] - 332:35, 336:17, 337:40, 338:6, 339:29, 364:33, 364:42, 365:11</p> <p>episodes [4] - 364:18, 364:20, 364:30, 365:9</p> <p>EPPIC [1] - 359:43</p> <p>equal [1] - 295:44</p> <p>equally [1] - 305:14</p> <p>especially [8] - 272:33, 273:30,</p>	<p>275:4, 275:20, 327:46, 336:47, 343:45, 350:47</p> <p>essential [2] - 279:41, 286:22</p> <p>essentially [8] - 303:29, 306:13, 312:40, 314:5, 341:12, 350:30, 351:10, 362:20</p> <p>established [5] - 301:36, 301:40, 306:46, 335:43, 339:25</p> <p>estimate [1] - 355:28</p> <p>Europe [3] - 329:39, 330:31, 342:14</p> <p>evaluate [1] - 299:29</p> <p>evaluation [4] - 281:39, 337:35, 340:10, 352:43</p> <p>evaluations [4] - 327:24, 338:46, 340:2, 340:7</p> <p>evening [1] - 275:35</p> <p>evidence [40] - 264:6, 264:18, 264:24, 264:35, 274:29, 275:1, 288:4, 288:15, 300:2, 300:20, 311:18, 313:42, 314:9, 314:17, 314:30, 314:39, 314:43, 314:47, 315:5, 316:19, 320:24, 321:26, 324:4, 324:20, 324:36, 324:39, 326:14, 334:16, 334:42, 337:43, 337:44, 339:36, 341:39, 347:17, 349:23, 356:20, 361:32, 362:45, 363:19, 365:42</p> <p>evidence-based [14] - 264:6, 311:18, 313:42, 314:9, 314:17, 314:30, 314:39, 314:47, 316:19, 320:24, 334:16, 339:36, 341:39, 347:17</p> <p>evolution [2] - 325:31, 330:24</p> <p>evolve [1] - 311:28</p> <p>evolved [2] - 303:20, 331:45</p> <p>exacerbation [1] -</p>	<p>278:2</p> <p>exact [1] - 270:47</p> <p>examine [1] - 316:10</p> <p>examined [5] - 264:43, 276:9, 293:15, 302:18, 321:28</p> <p>example [41] - 278:18, 280:20, 285:30, 296:21, 301:38, 304:1, 304:13, 304:21, 304:38, 306:2, 306:20, 307:45, 309:10, 309:28, 310:29, 312:1, 312:28, 312:29, 312:34, 313:1, 314:19, 314:32, 315:16, 315:19, 315:28, 315:46, 316:11, 317:10, 317:12, 319:33, 320:20, 320:26, 320:45, 322:37, 324:43, 342:37, 345:40, 347:26, 354:42, 355:6, 356:38</p> <p>examples [3] - 284:5, 334:20, 342:3</p> <p>exams [1] - 267:24</p> <p>Excellence [4] - 264:32, 314:34, 314:37, 321:47</p> <p>excellent [2] - 292:24, 362:45</p> <p>except [3] - 274:5, 278:8, 330:25</p> <p>excused [5] - 275:47, 292:45, 302:9, 321:9, 365:36</p> <p>Executive [2] - 264:31, 321:46</p> <p>exercising [1] - 271:4</p> <p>exist [6] - 289:35, 306:22, 328:32, 355:36, 360:20, 363:10</p> <p>existing [2] - 283:24, 283:44</p> <p>exists [2] - 328:2, 328:3</p> <p>expand [9] - 278:5, 279:45, 282:23, 306:11, 308:16, 311:42, 312:34, 313:10, 337:15</p> <p>expanded [1] - 348:13</p> <p>expect [1] - 323:11</p> <p>expectant [3] -</p>	<p>277:28, 286:40, 286:45</p> <p>expectations [4] - 350:9, 350:16, 350:42, 363:38</p> <p>expectations" [1] - 350:47</p> <p>expected [2] - 290:27, 316:47</p> <p>expenditure [1] - 356:23</p> <p>expensive [1] - 291:10</p> <p>experience [32] - 265:1, 269:11, 270:15, 272:14, 273:40, 274:13, 277:28, 280:37, 286:39, 286:45, 287:37, 293:33, 296:28, 296:36, 300:16, 301:6, 301:7, 305:29, 305:37, 309:8, 309:18, 317:34, 320:26, 327:30, 330:36, 333:24, 338:36, 341:31, 348:5, 352:43, 354:16, 362:22</p> <p>experienced [4] - 272:29, 284:21, 284:24, 319:33</p> <p>experiences [12] - 265:13, 273:1, 277:30, 284:37, 287:1, 287:15, 288:20, 305:32, 312:10, 313:36, 342:23, 361:39</p> <p>experiencing [4] - 269:43, 287:37, 300:46, 309:12</p> <p>experimental [1] - 342:30</p> <p>expert [2] - 265:37, 365:6</p> <p>expertise [11] - 296:29, 297:3, 331:27, 341:20, 346:35, 347:13, 353:33, 353:39, 354:4, 362:16, 362:36</p> <p>experts [3] - 301:17, 301:19, 358:3</p> <p>explain [9] - 283:8, 306:47, 308:44, 314:4, 314:33, 315:11, 333:36, 339:12, 339:47</p>	<p>explained [1] - 322:26</p> <p>explore [1] - 361:31</p> <p>exploring [1] - 362:37</p> <p>expose [1] - 323:14</p> <p>exposed [1] - 356:31</p> <p>exposing [1] - 359:36</p> <p>express [1] - 292:32</p> <p>expressed [3] - 265:45, 282:36, 363:17</p> <p>expression [5] - 308:38, 322:23, 332:32, 350:8, 353:10</p> <p>extended [2] - 336:25, 347:14</p> <p>extends [1] - 363:24</p> <p>extensive [1] - 327:38</p> <p>extent [12] - 306:19, 306:42, 309:2, 315:15, 315:26, 315:38, 316:12, 318:14, 328:31, 333:30, 342:11, 363:14</p> <p>extremely [5] - 281:16, 328:24, 346:5, 348:8, 348:10</p> <p>eye [1] - 307:31</p> <p>eyes [2] - 287:7, 287:10</p> <p style="text-align: center;">F</p> <p>fabric [1] - 277:10</p> <p>face [9] - 293:32, 293:40, 294:13, 318:16, 325:34, 325:36, 341:22, 350:32, 358:28</p> <p>faced [4] - 272:36, 293:42, 298:8, 306:7</p> <p>facilities [2] - 342:15, 345:47</p> <p>facing [4] - 264:35, 269:37, 298:10, 299:10</p> <p>fact [15] - 272:9, 281:15, 282:43, 300:25, 306:29, 319:6, 319:43, 320:22, 320:47, 321:1, 326:19, 333:34, 337:23, 337:40, 351:4</p> <p>factor [1] - 281:17</p> <p>factors [7] - 278:8, 278:11, 278:43, 282:47, 327:30,</p>
---	--	---	--	--

<p>333:26, 353:8 facts [2] - 338:30, 338:37 faculty [1] - 329:42 fade [1] - 332:21 fail [2] - 323:4, 330:34 failed [1] - 330:33 failing [1] - 312:3 failure [1] - 354:28 fair [4] - 342:29, 342:31, 342:39, 354:15 fairly [4] - 293:34, 303:46, 318:41, 325:10 fall [2] - 308:2, 343:32 familiar [2] - 300:13, 322:31 familiarity [1] - 320:33 families [5] - 274:12, 293:36, 315:37, 317:8, 321:4 family [23] - 265:21, 266:31, 266:35, 266:43, 268:40, 268:42, 269:26, 270:4, 274:4, 274:7, 274:13, 278:30, 284:17, 286:26, 291:44, 301:30, 305:33, 305:35, 312:11, 325:39, 330:15, 336:40 Family [1] - 304:38 fantastic [5] - 292:22, 298:21, 298:42, 299:13, 365:27 far [7] - 268:40, 273:44, 298:13, 305:37, 311:27, 350:30, 361:6 fashion [1] - 320:24 fashioned [1] - 319:9 father [1] - 278:25 fault [2] - 275:16, 352:1 fear [4] - 284:42, 284:44, 284:47, 302:21 fearful [1] - 285:4 feature [1] - 359:13 features [3] - 323:42, 332:23, 359:13 Federal [1] - 340:6 Federally [2] - 310:13, 310:35 fee [2] - 310:13, 311:10 feedback [3] - 291:5, 291:9, 292:31</p>	<p>feeds [1] - 287:41 feelings [4] - 269:39, 272:47, 274:26, 275:8 Fellow [1] - 322:8 FELS [2] - 362:44, 364:12 Fels [2] - 263:27, 362:42 felt [12] - 266:12, 266:35, 268:6, 269:34, 269:40, 270:1, 272:2, 275:13, 291:22, 351:19, 352:14 fertility [1] - 282:27 Festival [1] - 304:27 few [19] - 269:11, 270:10, 270:35, 274:8, 278:8, 284:8, 288:46, 291:22, 299:37, 300:40, 336:1, 336:19, 340:31, 341:1, 342:10, 343:26, 348:19, 349:42, 364:40 fewer [1] - 318:22 fiction [1] - 354:47 field [1] - 328:39 fight [1] - 273:18 figures [1] - 343:33 fill [1] - 352:38 filling [2] - 290:24, 352:42 final [2] - 320:29, 362:24 finally [4] - 264:29, 275:1, 284:29, 359:11 finance [2] - 345:20, 354:37 financial [4] - 278:29, 343:36, 356:30, 356:38 financially [1] - 278:24 financially-related [1] - 278:24 fine [1] - 339:20 finish [1] - 267:4 Fiona [1] - 263:35 first [54] - 264:12, 264:40, 265:13, 265:32, 270:34, 283:23, 283:30, 287:8, 291:30, 299:36, 300:41, 301:23, 302:40, 307:11, 307:30, 309:42, 318:33,</p>	<p>318:39, 323:42, 325:1, 325:17, 325:25, 331:13, 332:14, 332:42, 334:39, 335:8, 336:10, 336:16, 336:17, 336:28, 337:2, 337:37, 337:38, 337:40, 338:6, 339:11, 339:26, 339:29, 339:32, 340:4, 341:9, 341:25, 341:26, 344:30, 344:33, 344:38, 345:45, 348:41, 350:12, 351:11, 351:21, 361:31 firstly [5] - 276:46, 298:2, 328:32, 328:33, 349:8 fit [4] - 300:30, 330:8, 330:9, 348:43 fitting [1] - 362:28 five [5] - 303:8, 337:2, 338:33, 352:41, 365:4 fixed [1] - 364:22 flaw [3] - 331:5, 331:9, 345:16 flawed [3] - 331:7, 331:11, 331:12 fledged [1] - 338:4 flesh [1] - 280:33 flexibility [2] - 361:20, 361:26 flexible [3] - 325:10, 360:36, 361:2 flow [1] - 344:19 fluctuate [1] - 332:16 foci [1] - 359:1 focus [26] - 279:33, 288:8, 288:31, 294:46, 295:42, 295:46, 296:10, 296:29, 296:33, 296:40, 297:13, 298:4, 298:10, 298:14, 298:15, 298:41, 303:20, 303:32, 324:35, 329:40, 331:14, 348:34, 351:46, 355:42 Focus [1] - 345:27 focused [6] - 275:21, 289:31, 294:1, 315:7, 330:20, 359:37 focuses [1] - 297:8</p>	<p>focusing [5] - 295:28, 295:42, 298:7, 298:23, 355:43 foetal [1] - 282:31 follow [4] - 274:30, 281:44, 302:5, 362:47 follow-up [1] - 274:30 followed [2] - 290:16, 302:22 food [1] - 270:14 foot [2] - 273:11, 344:42 footing [1] - 295:44 forced [4] - 350:17, 350:27, 352:4, 352:46 forces [1] - 325:41 form [1] - 337:24 formed [4] - 294:24, 294:32, 295:3, 295:21 former [1] - 334:12 forms [7] - 340:24, 341:41, 341:44, 352:38, 357:2, 363:22, 364:2 forth [7] - 304:2, 310:24, 314:25, 316:20, 318:14, 318:31, 319:12 fortnight [2] - 267:10, 267:13 fortunate [1] - 304:33 Forum [1] - 359:23 forward [1] - 327:28 Foundation [2] - 299:1, 322:4 Founding [1] - 322:3 four [6] - 276:31, 306:12, 334:32, 344:31, 344:32, 345:29 fragile [1] - 357:11 fragmentation [1] - 279:22 fragmented [5] - 289:2, 289:16, 307:6, 314:5, 317:37 fragments [1] - 332:15 framework [6] - 296:5, 296:10, 299:29, 300:31, 300:35, 334:31 freak [1] - 275:9 free [2] - 269:17, 333:18 freedom [1] - 352:32 freeze [2] - 289:11, 357:12</p>	<p>frequently [4] - 278:26, 281:6, 284:37, 291:19 Friday [1] - 263:18 friend [1] - 269:6 friendly [1] - 340:44 friends [3] - 265:20, 269:47, 270:4 friendships [1] - 275:32 front [2] - 308:8, 348:35 frontline [1] - 316:33 full [1] - 328:41 fully [4] - 270:23, 338:4, 348:20, 358:33 fully-fledged [1] - 338:4 function [1] - 330:1 functional [2] - 273:33, 333:3 functioning [2] - 264:37, 357:37 fundamental [2] - 279:40, 345:16 funded [17] - 288:47, 289:28, 289:31, 290:32, 292:26, 310:13, 310:35, 311:9, 338:34, 343:4, 344:17, 349:32, 355:5, 355:11, 356:37, 356:43 funding [27] - 289:26, 289:30, 290:32, 304:34, 307:18, 307:19, 307:21, 310:38, 310:39, 310:44, 311:1, 311:16, 311:23, 311:27, 316:3, 316:4, 316:6, 339:33, 340:7, 351:17, 355:8, 355:12, 355:23, 357:2, 357:13, 357:17, 357:18 future [2] - 298:38, 364:29</p>
G				
<p>gain [1] - 316:17 gaining [1] - 303:24 gains [1] - 318:45 game [3] - 298:34, 298:39, 323:3</p>				

<p>280:14, 280:17, 280:20, 280:28, 280:38, 281:9, 283:13, 283:19, 283:24, 284:39, 285:20, 285:34, 285:36, 286:19, 286:23, 286:36, 287:16, 288:5, 288:28, 288:41, 289:11, 289:21, 289:27, 289:28, 289:38, 289:39, 290:36, 290:37, 292:19, 292:20, 292:23, 292:25, 292:29, 292:31, 292:35, 292:38, 292:39, 294:1, 294:6, 294:41, 295:30, 296:45, 297:33, 301:17, 301:21, 302:31, 302:36, 302:41, 303:12, 303:13, 303:19, 303:21, 303:25, 303:28, 303:39, 303:41, 304:1, 304:4, 304:8, 304:22, 304:25, 304:28, 304:45, 305:10, 305:13, 305:20, 306:17, 306:32, 307:4, 307:9, 307:10, 307:15, 307:16, 307:20, 307:28, 307:36, 308:3, 308:19, 308:22, 308:31, 308:33, 308:42, 309:3, 309:7, 309:15, 309:16, 309:18, 309:39, 309:41, 310:22, 310:27, 310:31, 310:43, 311:26, 311:40, 312:10, 313:9, 313:15, 313:32, 313:35, 313:36, 313:37, 313:39, 313:45, 313:47, 314:24, 314:27, 314:31, 314:45, 315:4, 315:14, 315:17, 315:22, 315:37, 315:40, 315:45, 316:6, 316:33, 316:35, 316:36, 316:37, 316:41, 316:42,</p>	<p>316:43, 316:44, 316:47, 317:7, 317:38, 318:17, 318:29, 318:30, 318:32, 320:3, 320:5, 320:6, 320:7, 320:8, 320:11, 320:26, 320:27, 321:2, 322:22, 322:28, 324:17, 324:23, 325:42, 325:44, 326:29, 326:47, 327:15, 327:16, 327:32, 327:33, 327:36, 328:32, 328:34, 328:39, 329:1, 329:2, 329:3, 329:15, 329:16, 329:18, 329:20, 329:29, 330:8, 331:35, 331:38, 334:3, 334:47, 335:20, 337:31, 340:8, 342:45, 343:24, 343:28, 343:46, 344:1, 344:36, 345:5, 347:16, 347:21, 347:27, 347:38, 348:6, 349:9, 349:17, 349:21, 350:31, 351:6, 351:26, 351:34, 351:36, 352:31, 352:44, 353:21, 353:28, 353:37, 354:7, 354:8, 354:13, 354:17, 354:29, 354:35, 355:19, 355:27, 355:29, 355:36, 355:44, 356:41, 357:1, 357:3, 357:10, 357:27, 357:34, 357:38, 358:32, 358:38, 358:41, 358:46, 358:47, 359:6, 359:14, 359:27, 359:28, 359:32, 359:44, 359:45, 360:6, 362:2, 362:25, 362:27, 362:30, 362:31, 362:36, 362:38, 364:17</p> <p>HEALTH [1] - 263:5 healthcare [1] - 283:11 healthier [1] - 329:14</p>	<p>hear [8] - 264:13, 264:17, 264:22, 264:29, 264:46, 343:45, 363:29, 364:21 heard [15] - 289:6, 300:2, 302:39, 303:16, 312:12, 324:42, 327:47, 329:46, 347:47, 352:28, 359:19, 363:19, 363:34, 364:18, 364:19 hearing [2] - 264:16, 360:20 heartbreaking [1] - 272:17 heat [2] - 269:9, 269:10 Helen [1] - 324:36 hell [1] - 343:29 help [49] - 266:13, 266:39, 267:15, 267:26, 272:7, 272:10, 272:12, 272:17, 272:20, 272:27, 273:14, 273:19, 273:21, 274:16, 280:10, 284:45, 294:2, 294:13, 301:20, 315:1, 326:15, 326:16, 326:17, 326:21, 326:22, 326:26, 326:41, 326:43, 326:46, 327:6, 327:20, 328:8, 328:10, 328:21, 333:2, 333:13, 333:18, 333:20, 335:8, 335:44, 336:42, 340:37, 342:22, 349:46, 350:23, 350:42, 353:43, 353:47 help-seeking [3] - 326:15, 326:17, 333:2 helped [5] - 275:33, 333:29, 334:11, 340:15, 357:11 helpful [4] - 266:21, 271:3, 271:5, 289:22 helping [4] - 265:47, 266:39, 301:29, 340:28 helps [1] - 362:32 hence [1] - 291:27 Herrman [1] - 324:36</p>	<p>herself [1] - 267:5 hi [1] - 300:1 hide [1] - 268:30 hierarchy [4] - 290:8, 290:9, 290:11, 290:12 high [21] - 277:46, 280:39, 286:14, 294:4, 294:14, 294:38, 295:29, 300:21, 300:26, 300:27, 300:44, 309:28, 316:33, 326:2, 326:10, 326:12, 331:40, 338:2, 343:3, 351:46, 362:36 higher [5] - 284:27, 297:23, 300:44, 310:31, 356:14 highest [3] - 326:35, 326:38, 326:40 highly [7] - 295:34, 303:39, 339:35, 343:39, 346:15, 347:7, 356:2 hindsight [1] - 344:46 historical [1] - 331:45 historically [1] - 330:11 history [2] - 328:37, 329:14 hoardings [1] - 335:28 hold [2] - 269:30, 276:20 holidays [2] - 270:41, 270:43 holistic [4] - 347:36, 358:42, 358:47, 362:33 home [20] - 265:20, 267:30, 268:26, 268:40, 268:41, 270:26, 271:10, 271:12, 271:41, 280:22, 284:6, 284:7, 291:46, 304:43, 321:4, 335:36, 344:42, 347:9, 350:35, 365:25 home-based [2] - 347:9, 365:25 homeless [1] - 285:1 homelessness [1] - 356:24 homicides [1] - 350:2 honest [1] - 300:14 hope [2] - 280:2, 323:7</p>	<p>HOPE [1] - 298:18 hopefully [1] - 323:24 hopeless [2] - 266:12, 272:22 hoping [1] - 336:20 hormones [1] - 265:25 horrified [1] - 352:15 Hospital [7] - 264:23, 302:36, 303:12, 303:33, 304:40, 305:17, 305:47 hospital [44] - 264:25, 267:36, 267:39, 267:44, 268:26, 268:32, 268:37, 269:22, 269:39, 270:22, 270:28, 270:37, 270:43, 270:44, 271:17, 271:20, 271:35, 271:39, 274:30, 274:31, 276:40, 289:41, 289:42, 289:43, 289:45, 304:5, 305:22, 305:23, 321:1, 345:6, 345:7, 345:12, 351:13, 352:3, 352:22, 352:35, 353:14, 356:33, 356:44, 356:45, 357:8, 357:30, 359:4 hospital-centric [1] - 359:4 hospitals [5] - 275:6, 347:20, 347:23, 352:14, 357:6 hour [3] - 267:7, 271:31, 296:8 hours [10] - 268:41, 269:46, 270:4, 272:2, 273:46, 273:47, 275:34, 292:9, 304:8, 347:14 house [1] - 268:35 hubs [2] - 346:42, 362:30 huge [8] - 270:24, 275:36, 279:42, 289:46, 291:9, 341:12, 342:24, 354:34 human [2] - 286:38, 329:14 hundred [1] - 343:26 hundreds [2] - 288:10, 354:38 hyperactivity [2] - 265:17, 307:47</p>
---	--	---	---	--

<p style="text-align: center;">I</p> <p>iceberg [2] - 352:34, 353:11</p> <p>ICU [2] - 268:45, 269:11</p> <p>idea [13] - 272:7, 281:19, 306:9, 306:46, 312:16, 313:8, 323:2, 345:4, 345:13, 351:15, 352:34, 362:11, 363:41</p> <p>ideal [2] - 320:43, 323:23</p> <p>ideally [1] - 323:28</p> <p>ideas [1] - 360:19</p> <p>ideation [1] - 293:41</p> <p>ideations [1] - 301:1</p> <p>identification [1] - 278:45</p> <p>identified [3] - 264:5, 294:44, 300:45</p> <p>identify [2] - 264:6, 282:5</p> <p>identity [3] - 278:16, 278:23, 325:37</p> <p>idiosyncratic [1] - 290:28</p> <p>ignore [1] - 322:44</p> <p>ignoring [1] - 297:29</p> <p>ill [15] - 308:3, 329:20, 339:4, 339:12, 339:14, 339:44, 343:8, 343:9, 343:10, 344:19, 346:6, 351:39, 355:35, 356:42, 359:6</p> <p>ill-health [3] - 308:3, 329:20, 359:6</p> <p>illicit [1] - 284:30</p> <p>illness [69] - 272:12, 272:28, 273:13, 277:46, 278:9, 278:45, 278:47, 281:4, 281:12, 281:41, 283:25, 283:26, 283:29, 283:31, 283:32, 283:44, 283:45, 292:3, 305:34, 308:21, 319:46, 322:35, 322:45, 323:13, 323:35, 323:43, 323:47, 324:8, 325:20, 326:16, 326:25, 330:21, 330:28,</p>	<p>332:35, 332:39, 332:42, 334:10, 334:14, 334:33, 335:5, 335:11, 335:31, 336:12, 337:3, 337:38, 338:11, 338:20, 338:27, 338:42, 338:43, 341:7, 341:11, 341:12, 341:32, 342:2, 344:7, 347:19, 349:19, 350:25, 351:2, 351:15, 354:16, 356:10, 356:21, 363:2, 363:22, 363:24, 364:3, 364:8</p> <p>illnesses [23] - 278:13, 283:33, 283:37, 283:38, 283:39, 286:15, 305:12, 307:11, 308:31, 310:28, 310:45, 313:26, 313:34, 316:23, 318:9, 318:41, 320:20, 329:9, 332:12, 341:46, 342:21, 350:47, 363:43</p> <p>image [1] - 329:4</p> <p>imagine [2] - 305:26, 335:10</p> <p>immature [1] - 286:38</p> <p>immediate [2] - 273:15, 323:46</p> <p>immediately [1] - 335:37</p> <p>immunisations [1] - 285:45</p> <p>impact [28] - 264:19, 277:41, 279:6, 279:8, 279:14, 282:27, 282:33, 282:34, 286:23, 286:29, 286:30, 286:34, 286:35, 287:22, 287:28, 287:30, 287:32, 288:24, 297:10, 297:17, 297:18, 297:34, 299:38, 300:21, 312:3, 313:34, 317:28, 324:8</p> <p>impacted [3] - 298:39, 298:40, 325:19</p> <p>impactful [1] - 311:20</p> <p>impacting [1] - 287:42</p>	<p>impacts [2] - 277:34, 297:47</p> <p>impairing [1] - 316:24</p> <p>impairment [2] - 313:26, 333:3</p> <p>impermeable [1] - 360:34</p> <p>implement [1] - 295:22</p> <p>implementation [3] - 295:18, 314:40, 354:28</p> <p>implemented [16] - 264:8, 290:14, 290:26, 294:30, 298:29, 298:47, 299:32, 300:19, 314:44, 334:17, 339:36, 342:12, 350:5, 350:6, 351:7, 354:31</p> <p>implementing [3] - 295:24, 296:2, 314:39</p> <p>implication [1] - 319:47</p> <p>implode [2] - 352:24, 357:12</p> <p>imply [1] - 323:21</p> <p>importance [8] - 285:20, 285:27, 288:35, 291:27, 295:44, 311:33, 338:39, 341:31</p> <p>important [47] - 276:47, 277:1, 279:21, 286:8, 286:13, 286:16, 287:16, 287:18, 288:17, 290:34, 291:21, 292:14, 292:40, 294:15, 295:35, 296:11, 296:26, 297:16, 301:19, 306:38, 315:32, 316:17, 316:20, 316:34, 316:36, 316:40, 317:30, 318:27, 320:5, 323:29, 332:7, 332:9, 336:45, 337:3, 338:41, 341:36, 345:4, 345:45, 347:29, 347:39, 358:38, 358:41, 359:26, 360:19, 361:39, 364:32, 365:22</p> <p>impossible [2] -</p>	<p>352:6, 353:5</p> <p>impression [1] - 268:8</p> <p>impressions [1] - 363:23</p> <p>impressive [1] - 322:17</p> <p>improve [8] - 295:7, 295:36, 295:37, 303:23, 311:22, 314:46, 337:39, 339:26</p> <p>improved [11] - 339:3, 339:11, 339:14, 339:44, 340:39, 340:41, 341:43, 362:13, 362:19, 363:18, 363:21</p> <p>improvement [8] - 327:22, 327:25, 327:27, 328:7, 351:27, 352:9, 352:10, 363:23</p> <p>improvements [3] - 328:6, 349:20, 349:21</p> <p>improves [3] - 295:39, 342:1, 355:1</p> <p>improving [4] - 266:28, 294:24, 295:4, 327:20</p> <p>in-laws [1] - 278:31</p> <p>inadequate [2] - 289:8, 327:7</p> <p>incidence [2] - 304:18, 331:42</p> <p>incidents [1] - 300:47</p> <p>include [8] - 300:32, 300:33, 313:4, 326:9, 326:11, 327:12, 327:13</p> <p>included [2] - 326:46, 327:15</p> <p>includes [3] - 336:10, 337:16, 358:42</p> <p>including [8] - 296:45, 304:5, 326:10, 331:26, 332:8, 334:23, 345:25, 356:24</p> <p>income [1] - 278:29</p> <p>inconsistencies [1] - 315:27</p> <p>inconvenient [1] - 271:42</p> <p>incorporated [1] - 303:28</p> <p>increase [7] - 282:28, 282:29, 319:7, 319:13, 319:20, 319:21, 332:27</p>	<p>increased [3] - 300:47, 317:27, 325:42</p> <p>increases [2] - 332:26, 332:28</p> <p>increasing [7] - 294:39, 294:40, 295:14, 318:43, 318:47, 337:21, 349:28</p> <p>incredibly [3] - 329:21, 359:16, 361:38</p> <p>indeed [6] - 302:24, 302:47, 310:43, 313:16, 317:36, 349:23</p> <p>indefensible [1] - 359:46</p> <p>independence [2] - 307:36, 325:39</p> <p>independent [1] - 286:40</p> <p>independently [2] - 333:30, 340:3</p> <p>indicate [3] - 283:19, 362:21, 363:4</p> <p>indicated [5] - 283:20, 283:21, 283:24, 283:29, 283:33</p> <p>indication [2] - 281:38, 337:11</p> <p>indigenous [1] - 328:23</p> <p>indistinct [1] - 333:43</p> <p>indistinct [1] - 363:11</p> <p>Individual [1] - 341:47</p> <p>individual [6] - 288:24, 292:2, 292:3, 301:34, 319:32, 331:3</p> <p>individualistic [1] - 290:28</p> <p>individually [1] - 288:12</p> <p>ineffective [1] - 356:3</p> <p>inevitable [1] - 364:9</p> <p>inevitably [1] - 316:4</p> <p>infant [31] - 277:24, 279:7, 279:14, 282:30, 282:33, 282:34, 283:22, 286:25, 286:31, 286:34, 286:36, 287:15, 287:20, 287:21, 287:28, 287:29, 287:33, 288:32, 288:36, 291:23, 291:32, 291:42, 291:43,</p>
--	---	--	--	---

<p>291:47, 292:7, 292:8, 304:1, 305:20, 314:26</p> <p>Infant [1] - 305:2</p> <p>infant's [6] - 277:27, 277:35, 281:16, 287:17, 292:16</p> <p>infants [15] - 287:6, 287:24, 287:31, 287:39, 289:24, 302:47, 305:13, 305:14, 305:27, 305:29, 305:40, 307:33, 307:37, 308:40, 309:16</p> <p>influence [1] - 358:20</p> <p>influencing [1] - 297:37</p> <p>informant [2] - 308:43, 308:47</p> <p>information [5] - 287:12, 313:43, 326:27, 335:29</p> <p>infrastructure [1] - 264:24</p> <p>informant [1] - 319:15</p> <p>initial [2] - 265:31, 351:17</p> <p>initiative [1] - 300:43</p> <p>Initiative [1] - 307:22</p> <p>initiatives [1] - 307:21</p> <p>innovations [1] - 360:6</p> <p>inpatient [30] - 271:18, 271:26, 281:7, 281:10, 283:15, 289:15, 289:38, 303:38, 306:9, 306:12, 306:15, 306:20, 306:26, 306:33, 306:40, 315:33, 345:8, 345:41, 345:45, 345:46, 346:3, 346:8, 348:1, 348:2, 351:44, 352:16, 357:26, 362:8, 364:19, 364:34</p> <p>inpatients [2] - 304:5, 315:28</p> <p>inpatients' [1] - 345:13</p> <p>input [1] - 311:9</p> <p>Insel [1] - 334:12</p> <p>inside [1] - 298:32</p> <p>instance [3] - 307:12, 332:2, 338:42</p> <p>instances [1] - 319:31</p> <p>instead [1] - 310:33</p>	<p>Institute [1] - 338:34</p> <p>institutionalised [2] - 352:33, 354:19</p> <p>institutions [2] - 347:23, 363:12</p> <p>instructive [1] - 333:37</p> <p>insufficient [4] - 272:25, 310:44, 311:1, 365:12</p> <p>integrated [6] - 290:33, 353:12, 353:13, 353:16, 359:7, 362:31</p> <p>integrates [1] - 358:43</p> <p>integrating [1] - 348:20</p> <p>integration [1] - 353:14</p> <p>intended [1] - 351:8</p> <p>intensity [2] - 322:24, 332:8</p> <p>intensive [5] - 272:30, 322:39, 328:16, 331:43, 336:25</p> <p>intention [1] - 344:35</p> <p>Inter [1] - 304:14</p> <p>inter [1] - 328:30</p> <p>inter-relationship [1] - 328:30</p> <p>Inter-School [1] - 304:14</p> <p>interact [1] - 287:20</p> <p>interaction [4] - 272:24, 283:17, 289:34, 325:41</p> <p>interacts [1] - 287:40</p> <p>interest [1] - 361:32</p> <p>interesting [2] - 316:10, 333:44</p> <p>internally [1] - 271:26</p> <p>International [1] - 322:12</p> <p>internet [3] - 319:25, 319:28</p> <p>interrupt [1] - 287:31</p> <p>intervene [3] - 311:45, 312:4, 338:26</p> <p>intervened [1] - 287:25</p> <p>intervening [2] - 311:47, 312:11</p> <p>Intervention [1] - 332:38</p> <p>intervention [17] - 264:3, 264:7, 279:2, 286:22, 304:17, 311:34, 332:30, 332:41, 334:38, 334:44, 336:9,</p>	<p>336:40, 337:16, 337:29, 337:30, 338:40, 356:19</p> <p>interventions [14] - 278:37, 305:28, 305:29, 311:18, 312:1, 312:2, 314:17, 314:30, 314:47, 315:18, 320:23, 334:15, 340:23, 341:46</p> <p>interwoven [1] - 295:36</p> <p>INTO [1] - 263:5</p> <p>intrinsically [1] - 295:36</p> <p>introducing [1] - 314:17</p> <p>invalidated [1] - 272:47</p> <p>invasive [1] - 270:19</p> <p>investment [3] - 338:41, 356:7, 356:39</p> <p>involve [1] - 349:11</p> <p>involved [6] - 270:19, 302:36, 314:40, 353:42, 361:45, 362:2</p> <p>involves [5] - 270:20, 276:33, 276:36, 276:42, 281:20</p> <p>involving [1] - 331:26</p> <p>iPhone [4] - 351:24</p> <p>Islander [2] - 284:1, 284:47</p> <p>isolated [3] - 268:42, 290:37, 312:21</p> <p>isolating [1] - 270:2</p> <p>isolation [4] - 269:40, 308:16, 308:34, 310:18</p> <p>issue [16] - 279:42, 282:42, 289:14, 291:9, 309:26, 317:21, 319:3, 319:42, 320:29, 328:1, 333:32, 348:1, 354:30, 355:21, 356:36, 358:39</p> <p>issues [27] - 264:35, 265:13, 280:16, 280:31, 282:40, 283:1, 292:20, 293:31, 293:40, 293:42, 294:6, 294:41, 294:42, 294:43, 298:5, 298:7, 299:20,</p>	<p>300:45, 301:4, 301:9, 301:21, 307:12, 313:25, 318:13, 318:38, 332:9, 348:35</p> <p>items [2] - 298:43, 320:21</p> <p>itself [2] - 356:16, 356:22</p>	<p>265:34, 265:37, 266:14, 266:25, 266:31, 266:47, 267:41, 267:43, 267:45, 268:26, 269:1, 270:10, 270:35, 271:8, 271:31, 271:40, 272:1, 272:3, 272:18, 272:46, 273:16, 274:7, 274:16, 274:24, 274:35, 274:36, 274:42, 275:8, 275:23, 278:34, 280:35, 287:40, 288:34, 305:36, 326:20, 326:45, 327:6, 330:15, 331:38, 331:45, 340:37, 341:40, 342:12, 343:23, 350:13, 351:10, 351:35, 363:25, 363:26</p> <p>kindly [1] - 344:26</p> <p>kinds [2] - 327:15, 343:31</p> <p>knowing [1] - 309:23</p> <p>knowledge [3] - 277:8, 314:38, 355:31</p> <p>known [5] - 274:41, 278:32, 282:47, 322:4, 355:6</p>
J				
<p>JAMA [1] - 339:28</p> <p>JANE [1] - 264:43</p> <p>January [1] - 265:29</p> <p>job [3] - 269:25, 292:22, 353:5</p> <p>Journal [1] - 359:26</p> <p>journal [1] - 332:37</p> <p>joy [2] - 280:2, 365:26</p> <p>joyful [1] - 287:21</p> <p>judged [1] - 284:43</p> <p>July [1] - 263:18</p> <p>JULY [1] - 365:46</p> <p>jump [1] - 291:46</p> <p>June [2] - 267:23, 268:37</p> <p>jurisdictions [1] - 317:6</p>				
K				
<p>Kalinda [13] - 264:17, 293:22, 293:25, 293:34, 293:42, 296:20, 297:36, 297:42, 297:44, 298:1, 298:13, 298:22, 298:27</p> <p>keep [8] - 270:14, 302:21, 324:7, 334:8, 344:41, 351:41, 352:26, 355:46</p> <p>kept [4] - 271:32, 272:3, 358:46</p> <p>key [11] - 264:5, 276:30, 277:22, 312:18, 316:28, 324:11, 325:18, 336:14, 347:39, 352:30</p> <p>kick [1] - 280:26</p> <p>kicks [1] - 329:26</p> <p>kids [3] - 329:9, 346:47</p> <p>Kilpatrick [1] - 353:25</p> <p>kind [52] - 265:18, 265:24, 265:26,</p>				
L				
<p>label [2] - 322:46, 333:19</p> <p>labelled [2] - 332:25, 333:14</p> <p>lack [8] - 280:16, 294:41, 299:11, 305:11, 310:20, 320:24, 341:38, 341:39</p> <p>Lancet [2] - 355:15, 359:26</p> <p>landmark [1] - 355:14</p> <p>language [3] - 287:23, 293:37, 298:3</p> <p>languishing [1] - 350:37</p> <p>large [11] - 278:44, 280:30, 300:26, 306:27, 308:35, 331:41, 343:40, 350:22, 356:43, 361:7</p>				

<p>largely [2] - 291:44, 351:44</p> <p>larger [2] - 300:27, 307:20</p> <p>last [18] - 298:29, 299:6, 299:33, 303:18, 304:34, 309:15, 319:16, 326:32, 326:34, 328:6, 332:10, 337:15, 339:28, 344:47, 349:42, 352:36, 355:15, 359:36</p> <p>late [7] - 283:34, 325:27, 329:25, 335:5, 336:18, 348:36, 350:19</p> <p>lately [1] - 348:30</p> <p>latest [2] - 338:34, 353:34</p> <p>latter [2] - 301:4, 301:7</p> <p>laudable [1] - 315:21</p> <p>laws [2] - 278:31</p> <p>lay [2] - 298:10, 346:19</p> <p>lead [2] - 311:19, 357:44</p> <p>leader [2] - 335:18, 358:19</p> <p>leaders [2] - 290:39, 298:20</p> <p>Leaders [2] - 298:18, 298:19</p> <p>leadership [11] - 299:14, 299:19, 353:3, 357:41, 358:1, 358:7, 358:24, 358:27, 361:36, 362:1, 365:34</p> <p>leading [2] - 297:14, 305:20</p> <p>learn [1] - 296:7</p> <p>learned [1] - 332:10</p> <p>learning [2] - 295:46, 297:13</p> <p>learns [1] - 287:21</p> <p>least [6] - 285:38, 326:3, 336:28, 338:7, 342:30, 345:45</p> <p>leave [2] - 266:34, 274:1</p> <p>led [11] - 289:26, 290:3, 290:5, 294:35, 295:5, 339:32, 360:39, 361:18, 361:33,</p>	<p>361:36</p> <p>leeway [1] - 360:39</p> <p>left [9] - 268:29, 273:16, 274:8, 274:24, 274:43, 305:23, 333:4, 347:42, 358:17</p> <p>left-hand [1] - 347:42</p> <p>length [3] - 278:46, 282:32, 336:44</p> <p>lens [3] - 353:14, 353:15, 353:20</p> <p>less [10] - 273:31, 289:8, 291:34, 292:26, 310:34, 312:2, 328:1, 328:5, 328:25, 347:34</p> <p>lesser [2] - 318:23</p> <p>lethal [1] - 330:45</p> <p>level [22] - 277:7, 277:8, 288:45, 288:47, 297:23, 298:9, 319:32, 323:38, 324:33, 327:37, 328:15, 328:27, 332:28, 333:1, 336:27, 337:43, 353:7, 355:23, 356:39, 365:10</p> <p>levels [6] - 278:6, 294:39, 294:40, 295:29, 340:40</p> <p>LGBTI [2] - 284:14, 284:15</p> <p>LGBTIQ [3] - 328:24, 361:17, 361:21</p> <p>licence [1] - 267:2</p> <p>lie [1] - 266:5</p> <p>life [42] - 271:19, 272:1, 273:34, 275:34, 277:3, 277:16, 277:27, 277:28, 278:8, 278:12, 278:19, 278:21, 283:23, 286:3, 286:19, 287:8, 287:9, 287:17, 288:32, 291:34, 298:11, 305:26, 313:27, 318:31, 325:1, 326:36, 326:38, 332:35, 335:7, 337:17, 342:21, 344:5, 346:17, 346:44, 350:40, 352:4, 356:5, 356:11, 356:12, 356:13, 364:38</p>	<p>life-span [2] - 326:36, 326:38</p> <p>life-threatening [3] - 344:5, 346:17, 352:4</p> <p>likely [14] - 278:13, 282:28, 282:29, 282:30, 282:32, 282:34, 282:36, 305:37, 311:19, 311:28, 315:1, 328:13, 328:14, 337:21</p> <p>limit [1] - 324:8</p> <p>limited [1] - 351:44</p> <p>line [2] - 298:15, 325:12</p> <p>linguistically [2] - 284:10, 328:19</p> <p>link [4] - 267:1, 331:31, 345:5, 361:9</p> <p>linkage [1] - 347:28</p> <p>linked [1] - 336:10</p> <p>links [2] - 344:12, 347:26</p> <p>Lisa [2] - 263:34, 264:5</p> <p>listed [3] - 284:8, 346:11, 347:15</p> <p>literacy [3] - 295:32, 295:43, 313:39</p> <p>literally [2] - 287:2, 290:20</p> <p>literature [2] - 332:36, 338:22</p> <p>live [5] - 265:8, 273:34, 289:17, 333:47, 359:7</p> <p>lived [1] - 267:33</p> <p>lives [3] - 277:25, 297:18, 349:45</p> <p>living [9] - 280:47, 283:25, 283:45, 284:17, 284:29, 285:34, 288:33, 290:21, 297:13</p> <p>Living [1] - 304:28</p> <p>load [1] - 292:34</p> <p>Local [1] - 304:23</p> <p>local [4] - 265:32, 274:6, 332:33, 335:18</p> <p>locally [1] - 265:37</p> <p>located [1] - 317:6</p> <p>locked [1] - 269:2</p> <p>logic [1] - 307:5</p> <p>logical [1] - 317:45</p> <p>logistical [1] - 285:17</p> <p>logistically [1] - 285:9</p> <p>lonely [1] - 275:9</p> <p>long-term [4] -</p>	<p>291:41, 363:2, 365:5, 365:12</p> <p>longitudinal [1] - 326:6</p> <p>look [22] - 268:27, 277:2, 279:46, 288:11, 288:18, 288:21, 290:2, 290:35, 295:27, 298:43, 300:35, 301:29, 327:5, 328:22, 328:36, 328:37, 329:7, 330:11, 343:27, 345:26, 359:33, 365:16</p> <p>looked [7] - 296:37, 296:42, 326:32, 339:29, 340:5, 346:7, 365:18</p> <p>looking [21] - 287:3, 290:23, 291:41, 292:6, 295:30, 296:1, 296:14, 296:38, 297:19, 298:8, 299:34, 301:46, 311:42, 327:33, 330:25, 336:22, 345:14, 351:11, 357:47, 358:11, 359:31</p> <p>looks [2] - 281:40, 362:7</p> <p>loose [1] - 274:42</p> <p>loosely [1] - 299:18</p> <p>loss [3] - 282:28, 291:31</p> <p>lost [3] - 284:2, 291:35, 349:35</p> <p>lounge [1] - 346:34</p> <p>love [1] - 302:2</p> <p>low [7] - 280:40, 318:40, 336:33, 350:8, 350:16, 350:46, 363:37</p> <p>lower [6] - 280:29, 291:16, 291:17, 310:30, 312:2</p> <p>luckily [1] - 275:26</p> <p>lucky [2] - 274:6, 275:27</p> <p>lunch [2] - 321:16, 321:19</p> <p>LUNCH [1] - 321:23</p> <p>LUNCHEON [1] - 321:21</p>	<p style="text-align: center;">M</p> <p>m'mm [1] - 338:44</p> <p>magnet [1] - 270:20</p> <p>magnetic [1] - 354:46</p> <p>main [2] - 331:18, 360:24</p> <p>mainstream [1] - 277:9</p> <p>mainstreamed [1] - 329:28</p> <p>mainstreaming [1] - 329:31</p> <p>major [7] - 265:15, 283:44, 324:47, 325:25, 326:34, 349:37, 356:32</p> <p>majority [3] - 280:38, 306:23, 327:37</p> <p>maldistribution [3] - 310:16, 310:21, 310:25</p> <p>malformations [1] - 282:29</p> <p>manage [11] - 266:40, 267:15, 274:24, 274:25, 275:32, 278:20, 283:2, 283:26, 285:35, 292:3, 308:22</p> <p>managed [2] - 280:44, 364:45</p> <p>management [7] - 307:14, 334:26, 334:27, 351:44, 351:47, 353:23, 362:3</p> <p>manager [2] - 276:35, 358:6</p> <p>managers [2] - 352:47, 358:9</p> <p>managing [2] - 269:25, 282:8</p> <p>mandated [1] - 357:40</p> <p>manner [1] - 351:7</p> <p>mapped [4] - 290:18, 290:19, 349:47, 355:17</p> <p>mapping [2] - 290:20, 331:24</p> <p>marginalised [1] - 358:10</p> <p>Marlborough [2] - 297:42, 298:2</p> <p>Maroondah [16] - 294:18, 294:20, 294:22, 294:23, 294:25, 294:27, 294:28, 294:47,</p>
---	--	--	--	--

<p>295:1, 295:4, 295:10, 295:20, 295:23, 295:42, 297:12 martial [1] - 299:18 Martin [1] - 300:18 mass [1] - 314:16 Massachusetts [3] - 312:29, 312:36, 317:1 massive [4] - 331:5, 341:9, 355:21, 356:13 Master [1] - 276:24 material [2] - 287:9, 364:15 maternal [6] - 276:41, 283:12, 286:35, 292:18, 304:21, 347:27 maternity [6] - 276:38, 292:22, 292:25, 292:28, 292:31, 292:39 matter [4] - 329:35, 336:1, 354:9, 354:38 Max [1] - 336:47 maximise [2] - 323:8, 336:26 MBS [2] - 311:11, 320:21 MCCLARE [1] - 293:15 McClare [5] - 264:17, 293:13, 293:17, 300:1, 300:41 MCGORRY [1] - 321:28 McGorry [11] - 264:30, 321:26, 321:30, 321:37, 322:17, 342:43, 359:11, 360:13, 361:30, 364:14, 365:36 MCPAP's [1] - 312:35 McSherry [5] - 263:29, 299:25, 299:27, 360:16, 361:28 mean [50] - 277:19, 278:28, 278:41, 279:20, 279:32, 280:40, 285:5, 286:14, 287:29, 289:8, 289:35, 290:4, 290:8, 290:9, 290:19, 291:8, 291:17, 291:30, 292:10, 292:27, 312:43, 315:11, 320:2, 322:26,</p>	<p>323:34, 325:5, 330:47, 332:39, 332:41, 336:31, 338:10, 339:13, 340:36, 342:5, 344:4, 344:33, 348:38, 350:10, 350:46, 351:30, 352:32, 353:11, 354:12, 355:41, 356:35, 358:40, 362:29, 363:27, 364:5, 364:33 meaning [4] - 296:12, 296:44, 332:15, 337:43 meaningful [1] - 314:44 means [9] - 277:29, 293:47, 303:43, 311:22, 323:10, 343:15, 352:6, 352:25, 355:29 meant [15] - 267:12, 267:16, 271:17, 276:46, 277:13, 280:2, 280:6, 289:12, 339:47, 345:37, 357:7, 360:27, 360:33, 362:21, 363:8 measurement [2] - 311:16, 316:19 measurement-based [1] - 311:16 measures [2] - 339:32, 349:24 media [3] - 272:9, 319:34, 332:45 Medical [2] - 322:9, 359:26 medical [19] - 276:40, 302:28, 305:24, 305:25, 305:28, 311:39, 316:41, 318:8, 328:46, 329:26, 346:15, 346:28, 354:14, 358:10, 358:11, 358:19, 358:43, 358:44 medicalisation [1] - 340:47 Medicare [4] - 266:26, 273:30, 289:12, 289:13 medicate [1] - 332:17 medication [19] - 265:45, 266:24, 268:30, 279:33,</p>	<p>282:20, 282:22, 282:25, 282:26, 282:27, 282:35, 282:43, 283:2, 285:36, 285:39, 286:9, 336:32, 336:34, 341:13, 341:26 medications [12] - 270:8, 270:11, 279:33, 279:34, 282:46, 286:10, 287:30, 288:23, 288:24, 288:25, 313:1, 341:3 Medicine [3] - 276:20, 276:24, 302:29 medicine [7] - 322:30, 329:4, 333:6, 333:43, 347:15, 353:30, 354:27 medium [1] - 320:34 meet [13] - 272:25, 275:3, 275:39, 280:8, 285:10, 288:44, 296:16, 309:28, 309:37, 309:38, 310:36, 326:4, 345:21 meeting [1] - 343:41 Melbourne [26] - 263:11, 263:13, 264:31, 265:8, 268:23, 268:38, 271:14, 271:16, 294:30, 299:31, 303:42, 306:14, 311:5, 315:29, 321:43, 331:34, 338:33, 342:15, 345:39, 345:42, 348:23, 349:30, 353:25, 353:27, 360:28, 365:18 melted [2] - 352:35, 353:11 members [4] - 295:32, 296:14, 297:4, 312:11 men [1] - 326:43 mental [272] - 264:23, 264:25, 264:30, 264:36, 264:37, 265:13, 265:28, 265:38, 268:3, 272:6, 272:11, 272:28, 273:13, 275:31, 276:46, 277:7, 277:9, 277:10, 277:13,</p>	<p>277:15, 277:22, 277:23, 277:38, 278:6, 278:33, 278:38, 279:4, 279:5, 279:23, 280:12, 280:14, 280:17, 280:20, 280:38, 281:9, 283:19, 283:24, 283:37, 283:39, 283:44, 285:20, 285:34, 285:35, 286:19, 286:23, 286:35, 287:16, 288:4, 288:28, 288:41, 289:21, 289:27, 289:28, 289:39, 290:36, 290:37, 292:19, 292:23, 292:35, 292:38, 294:1, 294:6, 295:30, 297:33, 301:17, 301:21, 302:31, 302:36, 302:41, 303:1, 303:13, 303:19, 303:21, 303:24, 303:28, 303:39, 303:41, 304:1, 304:4, 304:7, 304:8, 304:25, 304:28, 304:44, 305:12, 305:20, 305:34, 306:17, 306:31, 306:35, 307:4, 307:9, 307:10, 307:11, 307:14, 307:16, 307:20, 307:27, 307:36, 308:3, 308:15, 308:19, 308:21, 308:22, 308:31, 308:33, 308:41, 309:3, 309:7, 309:15, 309:16, 309:18, 309:39, 310:22, 310:27, 310:28, 310:31, 310:43, 310:45, 311:38, 311:40, 312:10, 313:9, 313:15, 313:23, 313:26, 313:34, 313:37, 313:39, 313:45, 314:27, 314:31, 314:45, 315:4, 315:14, 315:17, 315:22, 315:39, 315:44, 316:6, 316:23, 316:24,</p>	<p>316:33, 316:35, 316:37, 316:41, 316:42, 316:43, 316:46, 317:6, 317:37, 318:28, 318:30, 318:32, 318:41, 319:16, 319:46, 320:3, 320:6, 320:7, 320:20, 320:26, 320:27, 321:2, 322:28, 324:17, 324:22, 325:20, 325:42, 325:44, 326:4, 326:8, 326:9, 326:10, 326:16, 326:25, 326:28, 326:43, 326:47, 327:16, 327:31, 327:33, 327:36, 328:32, 328:34, 328:39, 329:1, 329:2, 329:18, 329:20, 329:29, 330:8, 330:21, 331:35, 331:38, 334:3, 334:14, 334:33, 334:46, 335:20, 337:17, 337:24, 337:31, 338:2, 338:43, 341:32, 342:1, 342:45, 343:23, 343:28, 343:46, 344:1, 344:36, 345:5, 347:16, 347:21, 347:38, 348:6, 348:47, 349:9, 349:19, 349:21, 350:30, 351:2, 351:6, 351:13, 351:14, 351:35, 352:14, 352:31, 352:44, 353:20, 353:28, 353:37, 354:8, 354:16, 354:17, 355:19, 356:21, 356:41, 357:2, 357:10, 357:27, 357:34, 357:38, 358:32, 358:38, 358:41, 359:6, 359:13, 359:27, 359:28, 359:32, 360:6, 362:2, 362:36, 363:2, 363:24, 364:3, 364:8, 364:17 Mental [24] - 264:32, 276:16, 276:17,</p>
--	---	--	--	--

<p>276:28, 276:29, 276:37, 302:35, 303:44, 304:39, 305:2, 311:36, 314:35, 321:42, 321:47, 322:4, 322:13, 322:22, 338:34, 349:47, 350:39, 355:16, 356:10, 358:17, 359:24</p> <p>MENTAL [1] - 263:5 mentally [5] - 343:9, 343:10, 344:19, 355:35, 356:42</p> <p>mention [1] - 326:47 mentioned [13] - 266:17, 267:19, 305:1, 313:11, 315:13, 317:2, 325:8, 326:34, 332:6, 333:22, 334:31, 340:47, 360:25</p> <p>Mercy [2] - 276:16, 276:28</p> <p>merit [1] - 318:16 message [1] - 363:31 met [2] - 309:42, 316:15 meta [1] - 339:27 meta-analysis [1] - 339:27 metaanalyses [1] - 338:29 metaphor [1] - 286:47 metrics [2] - 349:22, 349:26 metro [1] - 361:7 metropolitan [3] - 303:9, 306:14, 311:5 micro [1] - 332:15 microphone [1] - 264:46 mid-20s [2] - 325:9, 325:30 middle [19] - 293:34, 309:34, 310:11, 310:12, 310:20, 310:36, 311:25, 312:17, 314:23, 327:5, 327:39, 329:13, 331:18, 343:25, 343:43, 346:41, 347:5, 352:34 middle" [1] - 342:45 middle-aged [2] - 327:5, 347:5 middle-class [1] -</p>	<p>293:34 midwives [2] - 276:39, 281:31 might [63] - 265:14, 268:33, 280:21, 281:44, 281:47, 282:16, 282:21, 283:20, 284:5, 285:35, 286:3, 293:32, 293:33, 296:21, 296:39, 301:12, 302:21, 303:35, 305:29, 305:33, 306:7, 307:38, 308:7, 308:8, 308:17, 308:28, 309:7, 309:11, 309:18, 310:7, 312:10, 312:40, 313:35, 313:36, 316:7, 316:25, 318:28, 319:35, 319:38, 320:15, 320:17, 320:26, 320:44, 320:46, 323:38, 332:17, 332:21, 332:22, 333:14, 333:38, 335:38, 342:40, 345:39, 348:40, 349:35, 360:20, 360:28, 361:18, 364:27, 364:31 mild [11] - 272:28, 308:36, 309:40, 309:44, 309:46, 328:15, 339:3, 339:12, 339:14, 339:44 milder [1] - 308:32 milk [2] - 282:36, 282:37 million [2] - 314:37, 343:24 millions [2] - 354:38, 364:5 mind [1] - 307:39 Mind [1] - 304:23 mind's [1] - 307:31 mindful [2] - 300:24, 300:29 mindset [1] - 296:44 minimised [3] - 308:42, 313:27, 313:31 minimising [1] - 309:2 minimum [1] - 285:38 Minister [1] - 354:37 minority [2] - 309:20,</p>	<p>365:3 minute [3] - 266:47, 271:18, 339:46 minutes [4] - 267:3, 267:35, 312:39, 352:41 mirror [1] - 329:3 mismatch [2] - 306:9, 306:19 miss [1] - 347:45 missed [3] - 267:12, 267:16, 285:12 missing [13] - 309:34, 310:11, 310:20, 311:25, 312:17, 314:23, 327:39, 342:45, 343:21, 343:25, 343:43, 346:41, 352:30 mistake [1] - 345:35 misunderstood [2] - 313:28, 313:31 mix [1] - 348:31 mixed [1] - 337:19 mixing [2] - 330:31, 348:8 mobile [3] - 319:25, 351:22, 364:28 model [52] - 290:34, 303:18, 306:8, 307:13, 307:14, 308:39, 315:4, 315:14, 315:26, 315:40, 316:21, 317:21, 317:25, 323:33, 323:41, 324:17, 324:27, 324:28, 329:24, 329:25, 332:43, 340:43, 341:2, 341:14, 341:30, 344:12, 344:24, 344:25, 345:26, 345:27, 347:36, 347:41, 348:43, 349:6, 356:30, 357:21, 357:24, 357:25, 358:42, 360:18, 360:42, 360:45, 361:2, 361:7, 361:10, 361:31, 362:2, 362:21, 362:25, 362:28, 364:45 Model [2] - 341:47, 359:24 modeled [1] - 362:11 models [14] - 296:38, 303:21, 306:39, 307:10, 307:13,</p>	<p>356:38, 361:33, 361:36, 362:9, 362:16, 362:27, 362:37, 364:29, 364:31 moderate [6] - 308:32, 308:36, 309:40, 309:47, 318:40, 340:29 moderate-to-severe [1] - 340:29 moderately [5] - 339:4, 339:12, 339:14, 339:44, 343:8 modestly [5] - 339:3, 339:11, 339:14, 339:44, 345:41 modification [1] - 303:22 modules [4] - 296:33, 296:39, 296:42, 297:1 moment [15] - 266:42, 276:45, 277:45, 279:17, 281:45, 288:44, 298:27, 303:32, 304:32, 310:12, 315:33, 326:24, 342:39, 344:26, 350:31 moments [1] - 341:1 MONDAY [1] - 365:46 money [5] - 335:16, 356:40, 356:43, 359:32, 365:33 monitoring [3] - 311:7, 323:27 month [3] - 273:31, 289:9, 299:33 months [9] - 270:29, 270:30, 270:33, 270:40, 277:19, 287:8, 298:29, 364:39, 364:40 mood [1] - 337:17 morale [1] - 353:2 morbidity [4] - 328:47, 329:19, 334:13, 349:18 morning [10] - 264:1, 268:3, 268:25, 324:43, 326:34, 327:38, 329:47, 331:32, 348:1, 360:35 Morris [2] - 264:12, 264:41 MORRIS [1] - 264:43 mortality [2] - 334:13,</p>	<p>349:18 most [20] - 277:4, 283:41, 283:43, 291:31, 291:32, 304:35, 306:29, 306:35, 308:18, 308:30, 310:47, 314:47, 315:8, 315:37, 322:31, 337:23, 340:30, 355:28, 359:5, 364:35 mostly [3] - 330:21, 342:38, 356:3 mother [10] - 277:25, 277:38, 286:24, 286:25, 287:28, 291:23, 291:31, 291:33, 291:46, 346:14 mother's [3] - 277:23, 287:16, 292:15 mother-infant [1] - 286:25 motivated [2] - 349:39, 352:13 move [4] - 283:4, 287:46, 295:41, 330:14 moved [10] - 269:13, 271:14, 271:16, 271:32, 271:42, 272:1, 272:3, 330:22, 339:16, 346:16 movement [2] - 350:18, 363:28 moves [1] - 309:41 moving [5] - 306:44, 324:29, 339:16, 346:40, 359:42 MS [24] - 264:1, 264:45, 275:41, 275:47, 276:6, 276:11, 291:1, 292:45, 293:5, 293:12, 293:17, 299:22, 300:38, 302:9, 302:15, 302:20, 317:17, 321:9, 321:16, 321:25, 321:30, 360:13, 365:36, 365:42 multidisciplinary [3] - 336:11, 336:15, 348:14 multimodal [2] - 336:26, 336:31 Multiple [1] - 307:21</p>
---	--	---	--	--

<p>mum ^[10] - 265:28, 265:38, 267:2, 267:43, 268:5, 268:27, 273:44, 274:22, 278:21, 291:42</p> <p>mum's ^[1] - 273:10</p> <p>music ^[1] - 348:30</p> <p>myth ^[1] - 291:33</p>	<p>345:46, 346:2, 346:4, 346:36, 346:41, 346:44, 347:7, 351:33, 351:35, 355:23, 356:39, 360:28, 361:2, 363:8, 363:13, 364:23, 364:25, 364:27, 365:4, 365:5, 365:13</p>	<p>297:12, 313:42</p>	<p>351:31, 351:39</p>	<p>292:39, 304:22</p>
<p>network ^[14] - 283:11, 291:44, 292:19, 292:25, 294:32, 295:22, 295:42, 297:28, 297:41, 297:43, 300:16, 300:22, 300:24, 356:45</p>	<p>needed ^[12] - 268:31, 269:7, 272:29, 273:19, 309:25, 331:33, 331:37, 335:40, 335:41, 335:43, 347:2, 357:41</p>	<p>networks ^[3] - 352:35, 356:44, 357:31</p>	<p>non ^[2] - 270:19, 353:23</p>	<p>nurture ^[1] - 358:26</p>
<p>neurodevelopment ^[1] - 304:2</p>	<p>needing ^[2] - 329:15, 343:23</p>	<p>neurodevelopmental ^[1] - 307:46</p>	<p>non-communicable ^[1] - 353:23</p>	<p>nurtured ^[1] - 360:7</p>
<p>neurology ^[1] - 358:13</p>	<p>needs ^[57] - 272:25, 272:35, 273:9, 273:35, 273:37, 273:38, 274:12, 275:3, 275:39, 280:9, 280:30, 281:16, 282:17, 282:42, 285:10, 288:44, 290:4, 290:12, 290:38, 290:40, 290:43, 296:16, 296:20, 296:21, 297:29, 307:29, 307:35, 313:8, 313:9, 313:17, 315:22, 316:15, 316:22, 316:47, 328:16, 328:27, 329:22, 330:9, 331:14, 331:18, 331:20, 331:25, 331:28, 331:44, 331:47, 343:1, 343:41, 346:23, 348:27, 348:28, 348:34, 358:33, 360:47, 363:1, 364:9</p>	<p>neurotransmitters ^[1] - 270:21</p>	<p>non-invasive ^[1] - 270:19</p>	<p>nutrition ^[1] - 296:46</p>
<p>never ^[8] - 270:43, 272:22, 329:13, 330:4, 331:44, 350:21, 351:23, 353:12</p>	<p>new ^[3] - 317:12, 340:9, 340:38</p>	<p>newborn ^[2] - 277:27, 282:33</p>	<p>none ^[3] - 270:11, 345:12, 358:20</p>	<p>O</p>
<p>newspaper ^[1] - 335:28</p>	<p>news ^[1] - 355:41</p>	<p>news ^[1] - 355:41</p>	<p>normally ^[1] - 282:45</p>	<p>oases ^[1] - 324:20</p>
<p>next ^[18] - 268:3, 271:31, 271:41, 271:43, 276:6, 291:40, 293:12, 302:15, 309:36, 321:17, 324:13, 324:29, 324:33, 340:33, 351:38, 355:3, 358:26, 364:41</p>	<p>news ^[1] - 355:41</p>	<p>NICHOLS ^[5] - 321:25, 321:30, 360:13, 365:36, 365:42</p>	<p>North ^[1] - 315:29</p>	<p>observation ^[2] - 309:32, 310:16</p>
<p>Nichols ^[2] - 263:34, 264:5</p>	<p>negative ^[3] - 298:7, 358:14, 358:22</p>	<p>night ^[3] - 268:12, 287:31, 347:11</p>	<p>Northern ^[1] - 303:42</p>	<p>obstetricians ^[2] - 276:39, 281:30</p>
<p>NIGHTS ^[1] - 364:19</p>	<p>neglect ^[1] - 305:11</p>	<p>night's ^[1] - 364:19</p>	<p>northwest ^[1] - 348:23</p>	<p>obtaining ^[1] - 328:21</p>
<p>NINE ^[1] - 349:43</p>	<p>negligible ^[1] - 349:22</p>	<p>no-one ^[7] - 271:2, 274:41, 333:6, 333:7, 333:10,</p>	<p>NorthWestern ^[1] - 349:47</p>	<p>obvious ^[2] - 291:30, 311:46</p>
<p>no-one ^[7] - 271:2, 274:41, 333:6, 333:7, 333:10,</p>	<p>nested ^[1] - 347:22</p>	<p>not ^[13] - 304:22, 323:17, 331:21, 334:22, 334:34, 351:15, 354:35, 359:40, 359:42, 359:44</p>	<p>northwestern ^[1] - 331:34</p>	<p>obviously ^[19] - 267:1, 270:4, 273:9, 273:43, 274:14, 312:36, 325:33, 332:12, 332:44, 346:4, 346:23, 347:17, 347:38, 348:34, 348:47, 355:43, 355:46, 356:47, 361:25</p>
<p>network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>net ^[1] - 281:22</p>	<p>noting ^[1] - 317:31</p>	<p>Norway ^[2] - 335:3, 336:4</p>	<p>occasional ^[1] - 289:45</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>Netherlands ^[1] - 342:34</p>	<p>notional ^[2] - 329:45, 346:24</p>	<p>notions ^[1] - 311:17</p>	<p>occupationally ^[1] - 350:41</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>nowhere ^[3] - 289:44, 309:42, 340:30</p>	<p>occur ^[3] - 288:27, 344:2, 351:16</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>nuanced ^[1] - 324:41</p>	<p>occurring ^[3] - 304:32, 313:27, 330:43</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>number ^[21] - 264:11, 277:3, 282:16, 289:7, 293:41, 296:38, 298:20, 300:15, 301:1, 302:46, 304:12, 305:45, 308:27, 308:35, 312:37, 315:17, 326:5, 327:39, 335:33, 343:19, 343:27</p>	<p>occurs ^[2] - 291:33, 364:41</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>numbers ^[6] - 288:21, 292:27, 343:15, 350:1, 350:22, 351:31</p>	<p>October ^[1] - 355:14</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>numeracy ^[1] - 295:43</p>	<p>odds ^[1] - 315:38</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>numerical ^[1] - 349:46</p>	<p>offer ^[6] - 271:17, 303:46, 304:13, 311:22, 322:45, 362:17</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>numerically ^[1] - 345:46</p>	<p>offered ^[6] - 266:14, 268:16, 274:15, 336:40, 341:25, 342:13</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>nurse ^[1] - 292:19</p>	<p>offers ^[1] - 303:19</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>nurses ^[7] - 276:41, 283:13, 292:23, 292:29, 292:31,</p>	<p>office ^[2] - 342:24, 343:38</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>office-based ^[1] - 343:38</p>	<p>officers ^[2] - 301:26, 301:35</p>
<p>Network ^[7] - 280:1, 294:19, 294:20, 295:10, 295:20,</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>notwithstanding ^[1] - 338:41</p>	<p>often ^[19] - 278:29, 285:9, 289:43, 292:13, 292:32, 302:39, 305:25, 307:20, 308:42,</p>	<p>often ^[19] - 278:29, 285:9, 289:43, 292:13, 292:32, 302:39, 305:25, 307:20, 308:42,</p>

<p>312:12, 313:27, 325:19, 332:14, 333:2, 335:5, 337:19, 344:1, 352:13, 358:2 oil [1] - 330:30 old [8] - 313:24, 319:9, 330:19, 344:35, 351:13, 352:14, 359:42, 363:12 old-fashioned [1] - 319:9 older [5] - 269:38, 294:43, 306:17, 356:3, 359:43 once [10] - 267:10, 267:13, 269:19, 269:29, 272:12, 275:35, 280:15, 296:8, 320:35, 332:41 one [90] - 267:30, 269:3, 270:13, 270:36, 271:2, 271:28, 271:33, 271:35, 273:31, 274:1, 274:15, 274:28, 274:32, 274:41, 277:7, 280:16, 282:44, 288:9, 288:12, 288:13, 288:45, 289:9, 289:22, 291:4, 291:35, 294:31, 297:8, 298:29, 299:27, 299:36, 300:41, 301:39, 302:22, 303:36, 304:47, 305:21, 307:31, 307:38, 307:40, 311:11, 312:15, 312:18, 312:37, 313:20, 314:31, 315:29, 315:42, 316:2, 324:12, 326:32, 326:33, 326:34, 330:32, 332:6, 333:6, 333:7, 333:10, 335:3, 337:43, 338:7, 338:21, 338:34, 339:11, 339:20, 340:4, 340:5, 346:4, 346:42, 347:5, 349:35, 349:43, 349:44, 351:31, 351:39, 353:32, 354:42, 355:6, 358:37, 360:29,</p>	<p>361:18, 361:19, 362:6, 362:12, 362:24, 363:17, 364:14, 364:19 one's [3] - 278:8, 278:12, 307:31 one-stop [2] - 361:18, 361:19 ones [6] - 273:2, 273:3, 286:10, 340:32, 346:11, 360:29 ongoing [6] - 283:32, 288:36, 301:36, 302:3, 323:26, 364:23 online [1] - 266:2 onset [13] - 278:2, 278:33, 279:3, 279:35, 318:15, 319:24, 324:37, 324:42, 325:20, 329:3, 337:38, 338:11, 338:15 Ontario [3] - 314:33, 314:34, 314:36 open [1] - 328:4 opening [2] - 273:46, 275:34 operate [4] - 344:17, 345:22, 347:8, 352:36 operating [5] - 288:43, 300:5, 331:33, 352:2, 353:6 operational [1] - 338:1 opine [1] - 264:36 opinion [4] - 319:5, 321:32, 338:41, 341:29 opportunities [1] - 307:18 opportunity [4] - 285:33, 349:14, 349:16, 356:13 optimism [1] - 363:17 optimistic [6] - 358:1, 359:14, 359:16, 360:2, 360:10, 363:42 options [1] - 348:19 organisation [1] - 314:36 Organisation [1] - 347:21 organisations [3] - 279:46, 279:47, 364:7 organise [2] - 274:35, 274:44</p>	<p>organised [3] - 271:22, 272:1, 285:9 originally [1] - 364:44 origins [1] - 331:46 Orygen [9] - 264:32, 306:25, 321:46, 342:32, 348:24, 349:32, 353:46, 359:12, 364:44 otherwise [4] - 316:7, 317:45, 322:4, 345:12 ought [1] - 333:4 ourselves [3] - 268:16, 314:12, 356:18 out-laws [1] - 278:31 out-of-home [1] - 304:43 outcome [8] - 311:15, 336:25, 337:8, 339:26, 339:31, 340:5, 340:13, 350:30 outcome-based [1] - 311:15 outcomes [20] - 294:25, 295:15, 295:34, 295:35, 295:37, 295:39, 295:43, 311:12, 311:18, 311:23, 314:44, 316:20, 334:33, 337:39, 339:3, 339:13, 339:30, 339:42, 339:43 Outcomes [1] - 339:11 outline [2] - 276:29, 303:34 outpatient [9] - 271:17, 283:14, 306:20, 306:23, 306:34, 306:36, 306:40, 315:28, 316:7 outreach [3] - 347:9, 361:2, 364:28 outset [1] - 279:36 outside [3] - 273:42, 273:47, 346:27 over-medicalisation [1] - 340:47 over-treatment [1] - 341:10 overall [4] - 289:1, 292:24, 295:30, 301:13 overcoming [1] -</p>	<p>350:24 overlap [1] - 316:41 overmedicated [1] - 336:33 overnight [1] - 268:1 oversee [1] - 357:43 overtly [1] - 341:19 overtreat [1] - 341:5 overtreatment [3] - 323:11, 341:2, 341:25 own [11] - 267:2, 273:16, 274:16, 274:25, 287:41, 296:14, 297:2, 297:18, 301:6, 341:34, 350:24</p>	<p>parity [1] - 316:14 part [32] - 277:9, 278:38, 287:6, 292:24, 292:40, 294:8, 294:15, 297:27, 298:31, 299:2, 299:3, 301:40, 301:42, 301:46, 302:3, 304:25, 307:3, 308:26, 309:3, 314:40, 316:37, 316:44, 319:35, 320:8, 331:16, 331:20, 339:24, 346:25, 347:39, 347:44, 349:30 participation [2] - 313:12, 340:43 particular [16] - 279:15, 280:3, 280:6, 281:24, 286:39, 293:33, 297:17, 298:26, 298:39, 316:15, 317:44, 319:25, 335:2, 338:24, 347:39 particularly [14] - 280:41, 283:46, 284:34, 286:24, 304:8, 306:7, 317:45, 318:19, 325:19, 326:19, 327:1, 329:19, 336:45, 361:13 partly [4] - 314:37, 314:38, 320:13, 326:18 partner [2] - 278:26, 286:26 partnership [4] - 294:24, 294:33, 295:5, 304:13 parts [9] - 306:27, 310:28, 312:37, 319:44, 334:39, 336:39, 340:30, 344:32, 356:47 passed [1] - 271:39 past [6] - 284:38, 300:17, 305:7, 330:38, 360:40, 362:17 Pat [1] - 264:30 patch [1] - 359:42 patched [1] - 336:18 path [1] - 300:22 pathway [2] - 281:44, 289:4</p>
P				
<p>pace [1] - 302:21 pack [1] - 269:9 paediatric [12] - 314:20, 315:25, 315:36, 318:6, 318:17, 320:11, 320:21, 328:31, 328:34, 329:24, 329:25, 329:32 paediatrician [1] - 302:32 paediatricians [15] - 305:44, 310:14, 310:22, 312:28, 312:31, 312:40, 314:24, 316:32, 317:2, 317:5, 317:7, 319:44, 320:6, 320:15, 320:25 paid [2] - 305:8, 313:16 palliative [1] - 334:10 PANDA [1] - 279:47 paper [1] - 338:14 paranoia [1] - 342:22 paranoid [1] - 342:23 PARC [4] - 362:11, 362:13, 362:19, 362:21 parent [1] - 267:9 parent's [1] - 308:39 parental [1] - 305:34 parenting [1] - 312:1 parents [10] - 301:25, 305:27, 308:47, 309:10, 309:16, 309:21, 312:5, 313:43, 313:44, 320:24</p>				

<p>pathways [7] - 287:2, 290:15, 290:18, 309:46, 313:2, 314:18, 325:38</p> <p>patient [8] - 307:38, 323:15, 333:4, 336:17, 350:28, 352:7, 352:38, 352:42</p> <p>patients [34] - 269:8, 330:32, 331:20, 331:21, 331:25, 331:36, 331:37, 336:33, 337:7, 339:17, 339:27, 340:14, 340:17, 341:5, 342:26, 343:41, 344:19, 346:5, 346:7, 346:29, 350:17, 350:38, 351:13, 351:15, 351:45, 352:46, 354:2, 354:3, 354:15, 363:35, 365:3, 365:13, 365:18</p> <p>Patrick [1] - 321:25</p> <p>PATRICK [1] - 321:28</p> <p>pattern [4] - 314:19, 328:47, 329:3, 329:7</p> <p>paucity [1] - 310:20</p> <p>pause [1] - 298:34</p> <p>pay [2] - 356:15, 356:21</p> <p>payments [1] - 356:23</p> <p>peak [1] - 324:37</p> <p>peer [8] - 279:47, 313:16, 325:38, 361:33, 361:36, 361:40, 361:44</p> <p>peer-led [3] - 361:33, 361:36</p> <p>peers [1] - 290:6</p> <p>Penny [1] - 263:26</p> <p>people [157] - 264:27, 265:25, 269:38, 272:11, 272:27, 272:35, 273:35, 274:7, 275:3, 275:12, 275:39, 278:26, 289:6, 290:39, 291:22, 291:38, 291:40, 291:45, 294:25, 301:47, 303:20, 303:23, 303:38, 304:7, 306:23, 306:29, 307:22, 308:30, 315:22, 315:37, 315:44,</p>	<p>316:12, 316:25, 316:26, 318:28, 319:28, 319:33, 320:4, 320:27, 322:31, 324:7, 324:28, 324:33, 324:35, 325:4, 325:6, 325:18, 325:34, 325:43, 326:1, 326:4, 326:15, 326:26, 327:5, 327:8, 327:19, 327:37, 327:40, 327:46, 328:1, 328:2, 328:4, 328:19, 329:13, 329:34, 330:9, 330:20, 331:1, 331:18, 331:28, 332:7, 332:12, 332:13, 333:13, 333:23, 333:27, 333:38, 334:25, 334:33, 335:44, 339:4, 339:14, 339:25, 340:9, 340:28, 340:36, 340:41, 340:44, 341:10, 342:1, 342:22, 342:44, 342:47, 343:17, 343:27, 343:32, 343:33, 343:45, 344:2, 344:4, 344:41, 346:19, 347:3, 347:4, 348:40, 349:29, 349:43, 350:1, 350:20, 350:21, 350:22, 350:43, 351:1, 351:12, 351:13, 351:14, 351:17, 351:32, 351:35, 351:41, 352:1, 352:2, 352:7, 352:9, 352:14, 352:21, 352:27, 352:28, 352:43, 353:4, 353:35, 353:40, 353:47, 354:15, 354:26, 354:34, 355:27, 356:4, 356:11, 356:12, 356:14, 358:2, 359:6, 360:46, 362:2, 363:2, 363:12, 363:18, 363:24, 363:40, 364:25, 364:35, 365:29, 365:30</p>	<p>people" [2] - 339:12, 339:44</p> <p>people's [1] - 327:31</p> <p>per [36] - 277:2, 289:23, 301:39, 308:20, 308:27, 310:34, 319:7, 324:47, 325:43, 325:47, 326:3, 326:37, 326:40, 326:42, 326:43, 326:44, 327:7, 330:33, 340:14, 340:21, 340:26, 340:32, 343:12, 343:22, 343:26, 355:19, 355:20, 355:27, 355:28, 355:32, 355:34, 361:21, 361:23, 365:4, 365:5</p> <p>perceived [2] - 266:43, 297:9</p> <p>percentage [5] - 282:37, 286:14, 327:3, 327:40, 343:43</p> <p>percentages [1] - 343:11</p> <p>perception [1] - 309:11</p> <p>performance [1] - 298:15</p> <p>perhaps [12] - 280:22, 287:5, 290:21, 305:10, 306:45, 309:6, 315:45, 318:33, 320:37, 324:45, 332:23</p> <p>perinatal [22] - 264:14, 276:46, 277:7, 277:13, 277:15, 277:22, 277:45, 278:7, 278:38, 279:4, 279:42, 280:28, 280:39, 283:19, 285:21, 285:28, 288:4, 288:28, 289:21, 289:26, 290:36</p> <p>Perinatal [4] - 276:17, 276:29, 276:37, 280:1</p> <p>period [26] - 270:29, 277:17, 277:45, 277:46, 278:7, 279:43, 280:2, 280:4, 280:39, 283:27, 283:35, 285:21, 285:28,</p>	<p>287:17, 306:33, 325:8, 325:29, 325:44, 326:5, 326:35, 327:23, 334:43, 336:46, 350:2, 364:22, 364:47</p> <p>permission [1] - 270:21</p> <p>persistent [2] - 311:36, 322:32</p> <p>person [37] - 275:4, 281:38, 281:40, 288:38, 290:29, 290:30, 291:46, 301:39, 307:39, 308:43, 308:45, 318:25, 322:35, 323:21, 323:24, 323:28, 323:38, 325:40, 326:19, 332:3, 333:2, 334:7, 334:8, 334:9, 335:35, 336:20, 336:27, 336:42, 341:6, 341:22, 348:34, 349:36, 350:12, 358:17, 365:16, 365:21</p> <p>person's [4] - 269:29, 282:17, 335:7, 335:12</p> <p>person-centred [2] - 288:38, 332:3</p> <p>personal [3] - 275:16, 287:43, 287:44</p> <p>personality [5] - 283:46, 283:47, 332:24, 332:25, 337:18</p> <p>perspective [7] - 314:21, 315:36, 331:4, 334:40, 338:28, 338:40, 358:45</p> <p>peters [1] - 329:25</p> <p>phase [1] - 356:5</p> <p>phases [2] - 285:28, 346:17</p> <p>phenomena [1] - 318:9</p> <p>phenomenon [2] - 329:31, 348:39</p> <p>phenotypes [1] - 332:15</p> <p>philosophy [1] - 332:3</p> <p>phone [6] - 269:6, 269:44, 271:23, 312:43, 351:21, 351:22</p>	<p>phrase [2] - 286:40, 316:35</p> <p>phrases [1] - 280:41</p> <p>physical [16] - 278:13, 283:37, 299:18, 316:42, 318:9, 325:26, 329:4, 329:8, 329:14, 329:16, 329:29, 333:6, 347:15, 347:38, 362:31</p> <p>physically [1] - 285:46</p> <p>physiology [1] - 279:11</p> <p>pick [3] - 267:3, 281:40, 286:29</p> <p>picking [3] - 274:11, 307:25, 310:38</p> <p>picture [2] - 332:19, 332:21</p> <p>pictures [1] - 307:31</p> <p>piece [2] - 336:18, 362:12</p> <p>piloting [1] - 348:23</p> <p>place [9] - 275:27, 286:4, 286:16, 287:22, 303:19, 309:42, 326:21, 346:34, 362:9</p> <p>Place [1] - 304:38</p> <p>placed [3] - 292:18, 292:21, 292:34</p> <p>Placement [1] - 341:47</p> <p>places [1] - 347:7</p> <p>Places [1] - 300:19</p> <p>plan [5] - 271:1, 285:33, 285:42, 286:20, 300:32</p> <p>planning [12] - 277:4, 277:5, 277:16, 282:26, 283:22, 283:26, 285:36, 285:37, 285:43, 286:8, 351:34, 365:34</p> <p>plans [1] - 297:5</p> <p>plasticity [1] - 355:1</p> <p>platforms [4] - 348:7, 348:15, 348:16, 360:28</p> <p>Play [1] - 298:30</p> <p>play [2] - 287:20, 298:30</p> <p>playing [2] - 298:32, 323:5</p> <p>plea [1] - 320:3</p> <p>plenty [1] - 319:31</p> <p>pm [1] - 321:17</p> <p>pocket [1] - 293:36</p>
---	--	--	--	--

<p>point [38] - 266:26, 267:23, 274:11, 278:18, 281:10, 281:26, 286:16, 288:19, 290:1, 291:16, 291:18, 291:21, 291:24, 292:14, 296:31, 301:23, 304:10, 308:17, 314:2, 314:16, 317:31, 317:32, 317:34, 317:46, 318:6, 318:17, 320:31, 325:43, 326:2, 326:28, 329:14, 329:16, 332:46, 341:20, 344:39, 359:17, 360:23</p> <p>pointing [1] - 337:8</p> <p>points [5] - 290:16, 290:23, 328:34, 336:14, 345:25</p> <p>pointy [1] - 310:47</p> <p>police [1] - 344:8</p> <p>policies [2] - 307:23, 314:42</p> <p>policy [1] - 314:42</p> <p>Poll [1] - 309:14</p> <p>poor [2] - 325:42, 325:44</p> <p>poorly [1] - 343:38</p> <p>population [10] - 277:2, 289:23, 314:36, 343:23, 351:34, 355:33, 360:44, 360:47, 363:20, 363:46</p> <p>populations [1] - 328:24</p> <p>portal [1] - 347:33</p> <p>posed [1] - 282:21</p> <p>poses [1] - 319:4</p> <p>positions [2] - 357:12, 358:25</p> <p>positive [10] - 296:11, 296:12, 296:43, 296:44, 297:9, 298:44, 300:18, 360:10, 361:39</p> <p>Positive [23] - 264:18, 294:19, 294:47, 295:1, 295:10, 295:18, 295:20, 295:22, 295:25, 295:27, 296:4, 296:7, 296:17, 296:37, 297:12, 297:36, 298:18, 298:22, 298:44,</p>	<p>300:11, 300:15, 300:17, 300:31</p> <p>positively [1] - 359:15</p> <p>possibilities [1] - 351:16</p> <p>possible [12] - 286:8, 294:9, 323:30, 324:22, 324:24, 325:13, 325:21, 334:6, 338:13, 338:30, 363:43</p> <p>possibly [1] - 309:33</p> <p>post [2] - 274:44, 336:12</p> <p>post-diagnosis [1] - 336:12</p> <p>postgraduate [1] - 302:29</p> <p>postnatal [5] - 277:17, 281:32, 281:33, 283:34, 285:31</p> <p>postnatally [7] - 277:19, 277:34, 278:14, 281:31, 282:46, 283:3, 286:22</p> <p>postnatally-related [1] - 278:14</p> <p>potency [1] - 342:6</p> <p>potential [2] - 282:5, 342:24</p> <p>potentially [8] - 283:22, 312:21, 317:33, 322:32, 323:43, 335:10, 337:12, 337:16</p> <p>power [1] - 296:28</p> <p>powerful [3] - 297:27, 311:45, 365:25</p> <p>powerless [1] - 357:20</p> <p>practically [2] - 274:9, 285:9</p> <p>practice [8] - 290:1, 290:3, 299:39, 317:40, 320:21, 320:25, 365:7, 365:11</p> <p>practices [3] - 279:40, 290:13, 301:34</p> <p>practitioner [1] - 321:3</p> <p>practitioners [7] - 283:12, 314:25, 316:32, 318:18, 320:7, 320:14, 343:39</p> <p>pre [6] - 282:45, 283:24, 283:26, 283:44, 285:30,</p>	<p>290:20</p> <p>pre-conception [2] - 283:26, 285:30</p> <p>pre-existing [2] - 283:24, 283:44</p> <p>pre-pregnancy [1] - 282:45</p> <p>pre-primary [1] - 290:20</p> <p>precisely [1] - 324:40</p> <p>preconception [1] - 285:33</p> <p>precursor [1] - 334:45</p> <p>predicated [1] - 307:10</p> <p>predominance [1] - 310:30</p> <p>predominant [1] - 303:43</p> <p>predominantly [5] - 307:14, 310:13, 311:9, 319:8, 320:13</p> <p>pregnancy [25] - 277:17, 277:31, 278:14, 279:7, 280:1, 282:22, 282:27, 282:28, 282:30, 282:31, 282:32, 282:43, 282:45, 283:2, 283:22, 283:30, 283:33, 283:34, 285:35, 285:39, 285:43, 285:46, 286:7, 286:13, 286:15</p> <p>pregnancy-related [3] - 277:31, 278:14, 283:33</p> <p>pregnant [7] - 277:5, 277:17, 277:33, 279:12, 282:24, 288:44, 289:24</p> <p>premature [1] - 341:3</p> <p>prenatal [2] - 285:31, 286:5</p> <p>prenatally [1] - 285:47</p> <p>Prep [2] - 301:3, 304:17</p> <p>prepare [1] - 294:10</p> <p>prepared [1] - 321:31</p> <p>preparing [1] - 349:5</p> <p>prescribed [3] - 279:35, 282:25</p> <p>prescribing [1] - 279:39</p> <p>presence [4] - 305:11, 311:2, 313:34, 315:14</p> <p>present [9] - 284:44,</p>	<p>305:13, 307:44, 312:11, 313:17, 316:25, 318:28, 330:36, 335:38</p> <p>presentation [2] - 319:1, 319:13</p> <p>presentations [5] - 304:7, 318:42, 319:1, 319:8, 319:21</p> <p>presented [3] - 309:43, 318:25, 318:32</p> <p>presenting [2] - 301:20, 315:44</p> <p>presently [1] - 322:27</p> <p>resents [1] - 322:37</p> <p>President [1] - 322:12</p> <p>pressure [3] - 352:26, 354:36, 358:20</p> <p>pressures [2] - 356:47, 358:28</p> <p>pretty [10] - 267:42, 269:10, 269:30, 269:44, 270:12, 270:15, 302:20, 311:46, 342:25, 347:28</p> <p>prevalence [18] - 280:39, 308:23, 309:26, 309:27, 310:40, 310:45, 316:33, 316:40, 318:40, 319:16, 319:24, 326:10, 326:12, 326:25, 326:36, 326:37, 326:40, 331:41</p> <p>prevent [3] - 278:44, 278:45, 278:47</p> <p>preventative [1] - 323:34</p> <p>prevented [1] - 338:43</p> <p>preventing [2] - 286:18, 337:31</p> <p>prevention [16] - 264:2, 264:6, 278:42, 279:2, 279:19, 279:31, 323:33, 323:34, 323:36, 323:37, 333:34, 333:36, 334:2, 334:3</p> <p>previous [3] - 298:1, 298:2, 327:24</p> <p>previously [3] - 265:19, 284:25, 287:27</p> <p>price [1] - 365:20</p> <p>pride [1] - 304:12</p> <p>primary [53] - 273:26,</p>	<p>273:27, 273:36, 273:37, 277:26, 279:23, 279:39, 280:11, 280:44, 281:11, 283:10, 283:11, 285:16, 289:5, 289:38, 290:20, 290:22, 290:44, 291:11, 293:39, 294:9, 294:15, 294:21, 296:22, 300:26, 300:44, 301:2, 301:5, 301:8, 301:24, 304:18, 312:17, 312:41, 323:37, 327:37, 328:27, 331:32, 333:16, 335:36, 340:27, 343:1, 344:12, 347:20, 347:22, 347:26, 347:30, 348:7, 348:16, 348:20, 353:16, 359:8</p> <p>Primary [10] - 264:18, 293:22, 293:25, 296:20, 297:36, 297:42, 297:43, 297:44, 298:2, 298:13</p> <p>prime [1] - 356:10</p> <p>principal [5] - 264:17, 264:20, 293:22, 300:45, 301:18</p> <p>Principals [1] - 294:20</p> <p>principals [4] - 294:21, 295:2, 295:3, 300:16</p> <p>principles [2] - 278:39, 278:41</p> <p>prison [1] - 344:9</p> <p>prisons [1] - 356:24</p> <p>privacy [1] - 269:1</p> <p>private [8] - 268:19, 270:28, 283:13, 291:11, 311:2, 320:14, 320:25, 343:34</p> <p>proactive [4] - 295:6, 295:31, 323:10, 344:36</p> <p>problem [13] - 272:36, 306:32, 309:12, 319:15, 323:6, 328:16, 348:8, 348:40, 351:10, 354:28, 355:12, 357:18, 365:7</p> <p>problematic [1] -</p>
---	---	---	--	---

<p>320:10 problems [30] - 269:24, 269:37, 272:5, 286:18, 288:9, 304:19, 305:13, 305:25, 307:28, 307:46, 308:31, 308:42, 308:46, 309:3, 309:7, 309:17, 309:39, 310:28, 310:31, 313:35, 313:36, 314:13, 315:45, 316:34, 328:17, 328:20, 332:12, 335:4, 341:45, 348:32 process [9] - 281:23, 282:5, 282:8, 287:7, 287:43, 287:44, 302:4, 325:30, 331:26 producing [1] - 359:27 productive [4] - 356:5, 356:11, 356:12, 356:15 Productivity [2] - 355:42, 359:31 professional [6] - 295:46, 297:3, 332:31, 332:36, 347:16, 357:41 professionals [6] - 272:42, 272:45, 326:47, 327:16, 327:17, 347:2 professions [2] - 354:13, 354:17 Professor [15] - 263:27, 263:29, 264:29, 321:25, 321:30, 321:37, 321:42, 322:17, 324:36, 342:43, 359:11, 360:13, 361:30, 364:14, 365:36 professor [3] - 264:30, 299:25, 362:42 Program [1] - 304:13 program [21] - 269:22, 269:29, 295:19, 296:2, 296:6, 297:37, 298:30, 298:31, 298:42, 299:5, 299:6, 299:17, 300:4, 300:8, 300:14, 300:30, 304:15,</p>	<p>304:22, 312:30, 317:1 programs [16] - 296:16, 298:21, 298:26, 298:28, 299:30, 300:10, 300:33, 304:35, 324:20, 324:21, 336:41, 339:33, 341:32, 362:14, 362:15 progress [6] - 323:26, 332:22, 353:21, 353:22, 353:29, 362:12 progresses [1] - 324:8 progression [1] - 324:12 promise [1] - 342:12 promotion [2] - 304:25, 304:28 prompts [1] - 333:2 proper [1] - 340:8 properly [3] - 341:2, 353:12, 365:31 proportion [8] - 310:33, 312:22, 326:42, 327:6, 337:6, 343:8, 343:9, 356:14 proportional [2] - 341:6, 360:30 proportionate [1] - 310:32 propose [1] - 264:40 proposition [5] - 309:27, 317:37, 337:20, 338:19, 339:42 prospects [4] - 327:8, 333:46, 337:25, 342:1 protected [1] - 358:34 protection [1] - 285:2 proud [1] - 304:27 provide [21] - 277:34, 281:37, 301:32, 303:13, 303:37, 303:41, 304:4, 304:15, 305:5, 305:22, 305:42, 306:26, 312:47, 313:42, 317:8, 322:22, 334:10, 343:2, 347:32, 364:46, 365:2 provided [18] - 264:47, 276:11, 278:37, 293:17, 302:22, 303:33,</p>	<p>305:31, 305:43, 310:33, 310:34, 312:8, 313:13, 317:11, 322:21, 336:45, 351:33, 351:43, 361:6 providers [22] - 305:10, 306:10, 306:26, 309:37, 310:14, 310:15, 310:18, 310:21, 310:35, 311:2, 311:25, 312:41, 313:33, 313:47, 314:24, 316:19, 316:36, 316:43, 317:7, 320:11 providers/schools [1] - 311:26 provides [5] - 288:4, 304:28, 306:14, 327:26, 344:13 providing [5] - 312:27, 312:30, 328:23, 348:6, 351:36 provision [4] - 306:10, 306:19, 325:14, 355:23 psych [2] - 267:45, 268:11 psychiatric [10] - 268:8, 268:17, 268:20, 268:34, 268:37, 270:28, 346:3, 346:22, 346:28, 347:35 psychiatric-type [1] - 347:35 psychiatrically [1] - 347:37 psychiatrist [10] - 266:23, 266:33, 266:39, 270:37, 271:33, 271:34, 271:35, 274:33, 280:46, 358:18 psychiatrists [8] - 276:37, 283:14, 312:38, 318:19, 343:35, 347:17, 357:42, 363:35 Psychiatry [3] - 312:29, 332:38, 339:28 psychiatry [18] - 276:38, 289:12, 302:30, 322:44, 328:38, 329:39, 329:40, 329:42, 329:43, 330:12,</p>	<p>333:12, 334:22, 341:9, 348:46, 350:15, 350:20, 358:41, 359:41 psycho [8] - 327:12, 327:13, 334:23, 336:37, 341:24, 341:31, 341:35, 358:42 psycho-social [8] - 327:12, 327:13, 334:23, 336:37, 341:24, 341:31, 341:35, 358:42 psychological [3] - 341:40, 342:8, 364:20 Psychological [1] - 276:24 psychologist [5] - 266:19, 266:38, 280:46, 289:6, 301:38 psychologists [9] - 283:12, 283:14, 301:27, 305:44, 310:15, 310:23, 310:24, 314:25, 318:18 psychology [2] - 289:7, 300:18 psychoses [2] - 307:46, 324:46 psychosis [24] - 318:33, 324:37, 334:44, 335:4, 335:17, 335:29, 335:38, 336:17, 336:47, 337:12, 337:25, 337:41, 338:2, 338:4, 338:7, 338:17, 339:16, 339:21, 339:25, 339:30, 356:19, 363:28, 363:29 psychosocial [1] - 342:7 psychotic [12] - 317:43, 318:15, 332:24, 334:44, 335:6, 335:31, 338:3, 338:20, 338:42, 341:46, 342:21, 363:42 PTSD [1] - 342:20 puberty [5] - 265:25, 324:44, 325:7, 325:27, 329:19 public [16] - 266:47, 271:9, 272:8,</p>	<p>294:21, 332:45, 335:16, 335:22, 335:25, 335:28, 335:30, 343:13, 343:46, 349:17, 352:44, 356:41, 360:9 publication [1] - 355:14 published [1] - 339:28 pure [1] - 354:9 purely [2] - 347:37, 358:39 purpose [3] - 296:44, 341:4, 341:15 purposefully [1] - 313:14 pushing [1] - 292:41 put [23] - 265:44, 267:42, 269:30, 280:24, 287:33, 288:14, 288:33, 292:8, 292:38, 298:32, 299:44, 300:34, 301:25, 331:23, 333:19, 341:33, 343:11, 345:6, 345:39, 364:1, 364:10, 365:20, 365:29 putting [2] - 266:24, 359:3</p>
Q				
				<p>quadrant [2] - 345:33, 347:42 quadrants [1] - 345:29 qualifications [3] - 276:20, 302:27, 302:29 qualified [1] - 302:31 qualitative [1] - 288:19 quality [3] - 288:20, 351:43, 362:36 quantitative [2] - 288:9, 288:19 questionnaire [1] - 281:25 questions [20] - 275:42, 281:24, 281:26, 285:22, 291:2, 299:22, 300:40, 309:24, 317:17, 321:32, 321:39, 322:16, 325:3, 325:16, 337:28, 345:24,</p>

<p>347:41, 349:10, 356:27, 360:14 quickly [2] - 302:20, 354:39 quiet [2] - 269:7, 325:29 quite [28] - 266:12, 268:14, 268:42, 270:10, 271:5, 274:45, 281:47, 287:18, 288:23, 288:46, 289:1, 289:13, 293:42, 300:8, 300:20, 300:28, 301:37, 301:39, 307:20, 311:3, 313:15, 317:22, 319:15, 328:38, 349:9, 360:26, 363:40 quote [1] - 353:25</p>	<p>rates [7] - 310:27, 310:31, 318:43, 320:36, 326:25, 326:26, 327:19 rather [11] - 278:39, 296:2, 307:6, 311:12, 312:20, 317:29, 319:5, 344:25, 346:27, 353:14, 355:2 ratified [1] - 281:36 rationale [1] - 300:14 rationing [1] - 310:3 RCH [1] - 309:14 RCTs [1] - 339:29 re [1] - 272:1 re-organised [1] - 272:1 reach [4] - 281:25, 304:44, 320:43, 343:3 reached [2] - 266:25, 343:4 reaching [4] - 264:9, 329:32, 329:33, 354:25 reacted [1] - 298:35 real [12] - 265:21, 272:33, 272:36, 273:25, 298:3, 342:21, 342:27, 342:33, 344:2, 353:35, 354:31, 360:3 realise [2] - 351:9, 352:2 realised [2] - 265:26, 331:36 reality [5] - 342:6, 342:10, 342:29, 342:37, 344:26 really [162] - 265:12, 266:12, 266:13, 266:14, 266:24, 266:27, 266:29, 266:34, 266:40, 267:8, 267:10, 267:25, 268:9, 268:15, 268:32, 269:23, 269:27, 269:39, 269:46, 270:6, 270:14, 270:44, 271:2, 271:5, 271:11, 272:16, 272:17, 272:18, 272:19, 272:22, 273:2, 273:18, 273:20, 273:22, 273:30, 273:32, 274:6,</p>	<p>274:14, 274:21, 274:33, 274:37, 274:40, 274:43, 275:7, 275:8, 279:21, 280:10, 281:2, 281:46, 282:1, 282:20, 282:25, 283:21, 284:37, 286:8, 286:11, 286:13, 286:15, 287:7, 287:16, 287:17, 287:18, 287:39, 288:6, 288:17, 288:25, 288:30, 288:45, 289:9, 290:19, 290:34, 290:46, 291:8, 291:43, 292:14, 292:22, 292:24, 292:39, 294:15, 295:2, 295:35, 295:43, 296:11, 296:29, 297:16, 297:27, 297:31, 298:14, 298:23, 298:39, 299:19, 299:37, 300:30, 301:8, 301:18, 301:20, 301:21, 304:44, 304:45, 305:20, 306:33, 306:46, 307:10, 310:17, 310:44, 311:3, 314:35, 314:45, 315:32, 316:36, 316:47, 318:6, 318:9, 319:5, 319:18, 319:26, 320:43, 320:46, 322:30, 324:19, 326:11, 327:16, 329:15, 330:4, 330:13, 330:24, 331:46, 333:31, 337:8, 341:13, 343:40, 345:14, 345:15, 345:25, 347:30, 351:5, 352:26, 353:5, 353:27, 354:24, 356:39, 357:34, 359:4, 360:18, 360:30, 361:6, 361:32, 362:11, 362:36, 364:32, 365:22 realm [2] - 358:46, 358:47 reason [2] - 317:45, 320:32</p>	<p>reasonable [1] - 360:44 reasonably [2] - 293:36, 350:36 reasons [9] - 284:35, 285:17, 299:9, 299:17, 311:45, 312:13, 325:8, 325:18, 353:32 rebates [1] - 289:13 receive [7] - 270:33, 270:40, 291:5, 292:32, 304:33, 316:13, 347:45 received [1] - 339:6 receiving [3] - 270:17, 306:24, 306:30 recent [4] - 308:18, 310:41, 328:38, 349:23 recently [4] - 299:5, 326:20, 326:33, 338:14 recognise [3] - 316:22, 318:27, 335:31 recognised [3] - 291:18, 291:19, 292:13 recognising [1] - 344:25 recognition [2] - 313:8, 335:17 recommend [1] - 312:19 recommendation [3] - 275:22, 313:7, 317:30 recommendations [5] - 273:5, 311:31, 312:15, 312:47, 316:29 reconcile [1] - 364:30 recover [8] - 287:32, 287:34, 332:13, 332:22, 350:20, 350:22, 350:23, 363:32 recovering [1] - 351:41 recovery [12] - 287:43, 287:44, 292:15, 307:13, 323:9, 335:12, 336:27, 336:41, 336:42, 350:17, 363:43 recruit [1] - 358:26 recuperate [1] - 287:35 recurrent [2] - 311:37,</p>	<p>334:9 reduce [9] - 304:18, 324:12, 333:26, 334:3, 335:47, 344:18, 344:20, 349:18, 349:38 reduced [3] - 333:45, 356:22, 356:23 reducing [1] - 363:46 reduction [1] - 344:37 refer [5] - 277:15, 296:39, 312:24, 314:31, 321:38 reference [4] - 320:19, 345:30, 364:16, 364:25 referral [13] - 268:7, 268:17, 268:19, 271:24, 271:25, 271:27, 271:36, 301:26, 310:5, 310:8, 310:9, 335:37 referrals [1] - 313:4 referred [2] - 280:45, 314:34 referring [4] - 315:4, 326:1, 354:19, 364:47 refining [2] - 322:33, 322:47 reflect [1] - 298:34 reflection [1] - 333:24 reflections [1] - 275:45 reform [1] - 351:17 refugee [1] - 304:41 Refusal [1] - 304:13 refused [1] - 268:7 regard [1] - 350:7 regarding [1] - 285:44 region [7] - 294:22, 300:28, 315:43, 345:37, 345:41, 345:47, 360:27 regional [8] - 273:41, 303:8, 306:26, 311:4, 320:43, 360:42, 361:5, 361:7 regionalised [3] - 303:6, 303:7, 307:4 regular [1] - 310:8 regulation [1] - 319:11 rehabilitation [1] - 314:20 reimbursed [1] - 311:11 reinforced [1] - 275:8 relapse [2] - 278:2, 364:41 relate [3] - 325:35,</p>
R				
<p>radical [1] - 322:39 radiotherapy [1] - 322:40 raiding [1] - 357:9 rainbows [1] - 272:13 raise [1] - 280:10 Raise [1] - 313:41 raised [5] - 274:28, 286:30, 309:26, 310:40, 319:42 raises [1] - 364:21 raising [1] - 277:5 randomised [1] - 338:5 range [31] - 278:15, 287:14, 299:18, 301:28, 303:29, 303:37, 303:46, 304:35, 307:27, 307:32, 307:43, 308:2, 308:6, 308:10, 308:11, 310:15, 312:23, 313:37, 313:41, 320:16, 325:6, 326:9, 328:41, 331:27, 336:37, 336:41, 342:14, 347:14, 356:20, 356:23 rapid [1] - 319:7 rare [1] - 291:32 rate [6] - 278:6, 304:6, 349:31, 355:4, 357:7, 357:8</p>				

<p>346:22, 362:37 related [6] - 277:31, 278:14, 278:24, 283:33, 330:22 relating [1] - 327:11 relation [17] - 264:47, 265:13, 279:28, 291:5, 301:34, 306:7, 308:13, 311:32, 313:7, 319:34, 320:30, 321:32, 326:16, 327:26, 333:34, 338:23, 339:13 relationship [10] - 286:26, 288:31, 299:20, 305:35, 325:38, 328:30, 362:26, 365:21 relationship's [1] - 323:29 relationship-solving [1] - 299:20 relationships [9] - 269:26, 278:25, 278:30, 296:12, 296:44, 298:42, 298:45, 299:12, 301:36 relevant [6] - 269:24, 269:27, 269:35, 327:44, 331:28, 354:1 reliant [1] - 273:44 reluctant [1] - 265:44 rely [1] - 310:5 remain [1] - 323:25 remained [1] - 336:27 remains [1] - 358:38 remarkable [2] - 304:6, 314:36 remember [2] - 267:44, 325:35 remission [4] - 323:8, 323:25, 324:7, 334:7 remit [1] - 304:1 remote [2] - 271:9, 361:9 remove [1] - 358:44 removed [2] - 284:45, 285:5 repeating [1] - 349:11 replace [1] - 344:34 report [2] - 309:19, 358:6 represent [2] - 307:27, 307:29 representative [1] - 309:21</p>	<p>represented [1] - 309:4 representing [1] - 344:27 request [2] - 344:26, 349:6 require [2] - 289:40, 321:3 required [6] - 270:32, 289:15, 289:39, 301:30, 305:28, 364:31 requirement [1] - 320:21 RES.0001.0009.0681 [1] - 345:26 research [24] - 276:42, 287:47, 290:45, 300:20, 323:16, 331:24, 332:36, 335:45, 337:2, 337:8, 337:12, 338:31, 340:8, 341:34, 342:31, 342:33, 353:33, 353:34, 353:38, 353:44, 353:46, 354:4, 354:14, 358:4 researched [2] - 270:23, 298:24 researchers [2] - 299:29, 336:47 residential [6] - 362:7, 362:9, 362:10, 362:14, 362:47, 363:1 residual [1] - 352:25 resilience [9] - 294:2, 294:11, 298:9, 298:41, 299:11, 299:19, 301:13, 304:29, 350:24 resistant [1] - 354:43 resists [1] - 353:38 resolution [1] - 315:3 resolved [1] - 315:24 resolving [1] - 315:12 resource [1] - 359:39 resourced [3] - 329:47, 350:6, 365:28 resources [8] - 302:3, 313:41, 317:27, 355:33, 357:10, 357:27, 357:32, 364:46 resourcing [3] - 353:7, 360:39, 363:9 respect [9] - 277:18, 278:32, 279:13,</p>	<p>282:43, 283:2, 285:35, 353:32, 353:33, 363:21 respected [1] - 358:5 respects [1] - 279:4 respond [5] - 292:19, 323:4, 335:37, 335:44, 346:35 responded [2] - 305:18, 355:2 responding [1] - 331:41 responds [1] - 308:39 response [6] - 281:26, 287:11, 305:19, 305:20, 328:7, 331:38 responses [1] - 301:44 responsibilities [1] - 358:18 rest [3] - 287:35, 317:28, 355:44 restricted [2] - 269:44, 269:46 restructure [1] - 269:31 result [7] - 305:24, 307:6, 310:2, 310:3, 316:2, 320:1, 340:22 results [1] - 309:13 RESUMING [1] - 321:23 return [2] - 272:19, 339:39 revisit [1] - 317:21 Ric [2] - 264:22, 360:34 Richard [1] - 302:15 RICHARD [1] - 302:18 rife [2] - 354:13, 354:14 right-hand [1] - 345:33 rigid [1] - 360:36 rigidity [1] - 360:40 rigorous [2] - 299:42, 338:31 rings [1] - 281:11 Ringwood [1] - 293:26 rise [5] - 294:46, 300:42, 304:6, 318:42, 324:44 risk [28] - 277:46, 281:17, 281:40, 282:5, 282:8, 282:28, 283:42, 283:43, 284:1, 284:27, 284:34, 291:34, 301:47,</p>	<p>315:44, 316:5, 323:38, 325:42, 334:3, 334:27, 338:1, 338:2, 347:44, 351:44, 351:46, 352:5, 352:37, 358:19 risks [8] - 279:14, 282:30, 282:40, 291:23, 319:27, 323:14, 323:15, 324:12 risky [4] - 285:39, 286:10, 303:39, 315:46 road [1] - 267:33 Rock [1] - 299:6 role [15] - 272:26, 272:38, 275:28, 276:27, 276:30, 276:31, 276:33, 276:42, 294:8, 294:15, 298:31, 302:34, 358:10, 361:36 rolled [1] - 339:33 room [12] - 265:20, 267:43, 268:31, 268:46, 272:31, 273:26, 273:37, 292:9, 320:22, 321:4, 325:35, 348:29 Room [1] - 263:11 rough [1] - 343:24 roughly [1] - 343:23 round [1] - 267:7 Royal [14] - 264:23, 276:12, 302:36, 303:11, 303:32, 303:33, 304:39, 305:17, 305:47, 306:21, 307:3, 321:31, 359:18, 359:34 ROYAL [1] - 263:5 ruins [1] - 335:7 rules [1] - 325:10 run [7] - 267:27, 269:22, 271:4, 297:34, 306:2, 357:30, 358:12 running [3] - 271:5, 276:34, 312:35 rural [2] - 275:21, 361:9</p>	<p style="text-align: center;">S</p> <p>sadly [1] - 330:40 safe [3] - 346:38, 354:46, 354:47 salaried [2] - 317:7, 320:15 sample [1] - 309:21 SANE [1] - 364:7 sat [1] - 267:34 satisfaction [2] - 339:5, 340:40 saved [1] - 349:45 saw [7] - 265:32, 265:36, 266:23, 267:32, 268:6, 298:3, 341:9 SC [1] - 263:34 scale [9] - 331:13, 331:14, 345:21, 351:9, 351:28, 355:8, 355:10, 355:11, 356:37 scaled [2] - 324:24, 355:9 Scandinavian [2] - 336:3, 362:16 scene [1] - 354:36 schizophrenia [17] - 283:45, 330:21, 334:45, 335:4, 337:24, 338:16, 338:21, 338:23, 350:21, 350:23, 351:1, 363:22, 363:27, 363:28, 363:31, 363:36, 364:2 School [13] - 264:18, 293:22, 293:25, 296:20, 297:36, 297:42, 297:43, 297:44, 298:3, 298:13, 304:13, 304:14 school [58] - 264:19, 265:9, 267:3, 267:4, 267:13, 267:14, 267:16, 267:30, 268:42, 270:6, 270:40, 270:42, 273:46, 273:47, 274:1, 275:24, 275:26, 275:28, 293:32, 293:34, 293:39, 294:1, 294:4, 294:9, 294:14, 294:15, 294:38, 294:43,</p>
--	---	--	---	--

<p>296:14, 296:22, 296:25, 296:26, 296:30, 297:25, 298:1, 298:2, 298:16, 298:19, 298:30, 299:1, 299:39, 300:32, 300:36, 300:44, 301:3, 301:5, 301:9, 301:24, 301:39, 308:9, 310:23, 310:24, 326:3, 326:46, 335:35</p> <p>schools [27] - 294:22, 294:31, 294:40, 295:5, 295:23, 295:25, 295:33, 295:41, 296:6, 297:1, 297:4, 300:6, 300:11, 300:24, 300:25, 300:26, 300:27, 300:29, 300:34, 301:36, 301:37, 304:18, 316:32, 335:30, 347:26</p> <p>science [2] - 288:7, 354:47</p> <p>Science [1] - 322:8</p> <p>Sciences [1] - 322:9</p> <p>scientific [3] - 337:44, 338:22, 358:45</p> <p>screening [12] - 279:18, 279:31, 281:19, 281:21, 281:23, 281:28, 281:29, 281:31, 281:35, 281:37, 282:5</p> <p>sea [1] - 360:3</p> <p>sea-change [1] - 360:3</p> <p>seam [1] - 317:45</p> <p>seamless [1] - 323:30</p> <p>searching [1] - 349:37</p> <p>second [9] - 293:37, 307:43, 308:18, 336:10, 336:24, 337:39, 339:24, 339:35, 340:5</p> <p>secondary [11] - 283:11, 283:13, 285:17, 286:18, 289:11, 290:22, 290:45, 294:7, 294:22, 301:24, 301:32</p> <p>secondly [1] - 286:34</p> <p>section [2] - 329:41, 345:35</p>	<p>sectors [1] - 302:2</p> <p>secure [1] - 346:4</p> <p>see [49] - 265:39, 266:36, 278:15, 278:18, 281:25, 284:39, 285:43, 295:35, 297:17, 298:14, 299:38, 301:3, 301:9, 305:40, 307:18, 308:6, 308:7, 309:10, 309:40, 310:3, 310:4, 310:32, 310:33, 312:7, 312:8, 316:37, 316:43, 320:11, 324:44, 328:10, 328:47, 329:4, 329:18, 333:7, 333:10, 335:34, 343:44, 352:16, 352:38, 354:2, 358:47, 359:17, 360:25, 360:32, 361:35, 362:1, 362:27</p> <p>seeing [7] - 265:34, 266:17, 266:18, 266:19, 320:7, 337:6, 352:42</p> <p>seek [7] - 280:21, 294:13, 301:15, 328:10, 333:13, 335:44</p> <p>seeking [11] - 312:25, 313:30, 326:15, 326:17, 326:21, 326:22, 326:41, 328:8, 328:21, 330:9, 333:2</p> <p>seem [3] - 326:29, 351:16, 363:20</p> <p>sees [1] - 264:37</p> <p>select [1] - 265:36</p> <p>selected [3] - 299:8, 299:17, 318:3</p> <p>self [7] - 271:1, 287:42, 318:34, 318:44, 319:10, 332:17, 332:18</p> <p>self-harm [4] - 318:34, 318:44, 319:10, 332:18</p> <p>self-medicate [1] - 332:17</p> <p>Seligman [1] - 300:18</p> <p>sells [1] - 306:4</p> <p>senior [1] - 357:42</p> <p>sense [10] - 287:9, 287:42, 288:18,</p>	<p>294:11, 314:19, 318:20, 325:39, 342:22, 345:7, 365:13</p> <p>sent [4] - 267:47, 268:26, 336:19, 364:40</p> <p>separate [4] - 289:21, 314:12, 346:1, 346:30</p> <p>separated [1] - 358:33</p> <p>separately [1] - 314:6</p> <p>separation [1] - 317:46</p> <p>sequelae [1] - 278:47</p> <p>series [2] - 310:17, 310:35</p> <p>serious [18] - 268:11, 268:14, 303:39, 310:45, 311:1, 316:22, 316:24, 322:42, 323:43, 323:47, 328:1, 329:8, 335:10, 337:17, 337:23, 363:22, 363:24, 364:2</p> <p>seriously [5] - 272:42, 272:46, 325:19, 327:7, 355:35</p> <p>serve [1] - 290:5</p> <p>Service [4] - 304:39, 306:8, 330:30, 349:32</p> <p>service [42] - 276:32, 276:34, 276:35, 280:37, 281:12, 283:15, 284:39, 289:46, 292:24, 303:3, 304:33, 306:10, 306:31, 306:32, 307:4, 308:15, 308:22, 308:33, 310:6, 310:14, 311:10, 311:20, 312:21, 314:27, 315:5, 315:6, 316:2, 316:14, 316:43, 317:26, 317:35, 318:25, 325:13, 329:46, 330:1, 331:35, 340:28, 343:10, 351:6, 358:5, 358:21, 363:13</p> <p>serviced [1] - 304:45</p> <p>services [141] - 264:25, 272:34, 273:25, 273:43,</p>	<p>274:9, 275:2, 275:31, 275:38, 277:9, 277:11, 277:18, 280:12, 280:14, 282:2, 283:15, 284:2, 284:38, 285:2, 285:4, 285:8, 286:16, 286:20, 288:45, 288:46, 289:15, 289:21, 289:27, 289:28, 289:35, 289:38, 289:39, 290:18, 291:15, 301:28, 301:30, 302:42, 302:45, 303:7, 303:12, 303:13, 303:25, 303:27, 303:33, 303:37, 304:1, 304:12, 304:15, 305:1, 305:5, 305:21, 305:22, 305:42, 306:10, 306:14, 306:42, 307:2, 307:3, 307:7, 307:9, 307:15, 307:16, 307:20, 308:26, 309:25, 309:40, 309:43, 309:44, 310:32, 310:34, 310:43, 310:44, 311:22, 311:28, 312:22, 313:15, 313:17, 314:6, 314:10, 314:13, 314:14, 314:26, 314:28, 314:45, 315:12, 315:17, 315:18, 316:18, 317:8, 317:38, 318:29, 318:32, 320:39, 320:40, 320:41, 322:22, 323:17, 327:12, 327:14, 328:31, 328:32, 328:33, 328:35, 328:37, 329:32, 329:33, 330:8, 330:10, 330:43, 331:33, 335:20, 335:21, 336:45, 340:8, 340:31, 340:41, 343:5, 343:21, 343:28, 343:31, 343:37, 343:44, 344:13, 344:36, 344:39, 345:5, 345:14, 346:41,</p>	<p>347:32, 347:33, 352:2, 352:21, 352:31, 353:4, 358:33, 364:44, 365:1</p> <p>Services [3] - 276:16, 276:28, 303:44</p> <p>session [2] - 271:18, 275:35</p> <p>sessions [7] - 266:26, 267:27, 273:30, 274:34, 289:7, 289:8, 289:12</p> <p>set [7] - 302:46, 306:40, 324:21, 344:35, 346:32, 346:37, 351:16</p> <p>setting [14] - 280:44, 281:7, 283:4, 291:11, 291:12, 294:7, 296:15, 335:36, 341:18, 346:7, 347:3, 348:9, 348:31, 351:12</p> <p>settings [11] - 307:34, 316:18, 333:17, 333:25, 333:31, 339:34, 341:18, 352:16, 352:36, 357:15</p> <p>seven [1] - 327:23</p> <p>seven-year [1] - 327:23</p> <p>several [6] - 332:34, 345:46, 346:2, 346:41, 356:16, 356:22</p> <p>severe [8] - 283:46, 302:47, 305:25, 310:45, 330:21, 337:8, 340:29, 351:14</p> <p>severely [2] - 343:10, 351:38</p> <p>severity [10] - 305:12, 308:6, 308:11, 308:30, 309:40, 310:5, 312:3, 315:44, 318:40</p> <p>sexual [1] - 284:24</p> <p>shame [3] - 281:3, 284:41, 285:8</p> <p>share [1] - 275:45</p> <p>SHARING [1] - 296:28</p> <p>SHAUN [1] - 293:15</p> <p>Shaun [2] - 264:17, 293:12</p> <p>shelters [1] - 335:28</p> <p>shop [1] - 361:18</p> <p>shops [2] - 346:42,</p>
---	--	---	--	--

<p>361:19 short [6] - 293:5, 343:29, 346:33, 363:10, 364:35, 364:42 SHORT [1] - 293:10 short-term [1] - 346:33 shortage [1] - 310:25 shortening [1] - 335:12 shorter [1] - 312:2 shortfall [2] - 355:22, 357:17 shortly [1] - 325:17 show [7] - 299:13, 319:19, 324:21, 326:15, 326:35, 338:29, 338:30 showed [8] - 294:37, 294:39, 327:22, 335:15, 335:45, 335:46, 339:30, 355:18 showing [4] - 299:10, 330:32, 337:21, 338:5 shown [5] - 275:14, 287:22, 326:6, 337:2, 344:28 shows [6] - 279:22, 288:12, 288:13, 298:22, 300:21, 342:12 shrink [1] - 337:6 siblings [1] - 267:19 sick [1] - 275:15 side [2] - 270:12, 358:43 side-effects [1] - 270:12 sign [1] - 266:3 significance [1] - 355:12 significant [11] - 277:3, 303:21, 309:20, 309:45, 317:34, 327:25, 327:39, 343:8, 343:36, 349:13, 365:3 significantly [2] - 337:4, 340:15 signing [1] - 339:33 signs [6] - 323:42, 332:41, 335:17, 335:31, 337:38, 338:4 silence [1] - 272:19 silo [1] - 345:34</p>	<p>silos [1] - 324:29 similarities [1] - 296:24 simpler [1] - 312:2 simply [4] - 308:22, 313:37, 313:38, 334:24 simultaneously [1] - 265:34 single [6] - 267:9, 314:26, 317:47, 334:34, 343:38, 349:44 sisters [3] - 267:9, 274:15, 274:19 sit [1] - 320:10 sits [1] - 316:5 sitting [4] - 341:21, 352:34, 353:10, 356:44 situation [8] - 288:34, 309:32, 310:7, 315:34, 322:42, 323:23, 344:5, 352:27 situation's [1] - 341:43 situations [4] - 284:17, 298:33, 346:36, 352:4 six [1] - 364:39 size [2] - 296:25, 360:44 sized [1] - 345:41 skill [2] - 332:28, 346:32 skilled [3] - 335:45, 365:28, 365:31 skills [5] - 294:12, 295:7, 296:13, 299:14 Skype [2] - 270:36, 274:32 sleep [4] - 268:31, 287:31, 294:41, 296:45 slightly [1] - 348:3 slow [2] - 299:39, 342:16 slowly [2] - 352:35, 353:11 small [9] - 276:42, 288:12, 288:13, 293:36, 293:41, 300:26, 301:1, 306:33, 346:4 smaller [2] - 300:26, 360:46 smartphone [2] - 319:2, 319:24</p>	<p>snowballing [1] - 311:38 social [18] - 278:23, 311:40, 319:34, 325:33, 325:37, 327:12, 327:13, 334:23, 336:37, 341:24, 341:31, 341:35, 341:41, 358:39, 358:40, 358:42, 359:8, 359:45 socially [1] - 350:41 socio [1] - 310:30 socio-economic [1] - 310:30 socioeconomically [1] - 293:35 soft [3] - 350:8, 350:46, 363:37 softened [1] - 363:26 softening [1] - 363:41 solo [1] - 310:21 solution [3] - 266:14, 268:16, 359:37 solution-focused [1] - 359:37 solving [1] - 299:20 someone [5] - 266:17, 322:37, 332:46, 335:44, 355:1 something's [1] - 352:45 sometimes [6] - 273:35, 285:10, 288:11, 292:3, 319:11, 364:18 somewhat [1] - 328:14 somewhere [1] - 308:19 soon [2] - 265:32, 269:30 sophisticated [2] - 335:21, 335:25 sophistication [1] - 341:39 sore [1] - 333:9 sorry [12] - 279:25, 281:29, 283:39, 284:2, 286:43, 289:19, 312:46, 326:40, 326:41, 331:12, 339:19, 357:24 Sorry [1] - 333:10 sort [57] - 265:45, 266:13, 268:7, 269:20, 277:10, 281:8, 281:21, 281:25, 281:38, 282:44, 285:9, 287:19, 288:11, 288:34, 289:1, 289:28, 289:37, 290:24, 292:4, 304:26, 309:41, 315:39, 318:3, 318:16, 318:34, 320:2, 325:8, 328:26, 329:26, 329:32, 329:36, 329:40, 330:22, 342:19, 343:26, 345:21, 346:3, 346:8, 346:46, 347:3, 347:4, 348:14, 349:3, 350:42, 352:6, 352:23, 352:24, 353:5, 354:19, 355:16, 356:39, 357:33, 360:40, 361:7, 362:15, 363:13 sorting [1] - 309:45 sorts [8] - 280:31, 305:36, 308:2, 312:31, 320:12, 320:16, 323:9, 358:28 sought [2] - 274:15, 326:42 soul [1] - 349:37 soul-searching [1] - 349:37 sounds [2] - 300:8, 354:47 South [3] - 317:12, 340:9, 340:38 southern [1] - 306:27 space [3] - 317:22, 329:16, 330:14 spaced [1] - 342:24 spaces [1] - 346:30 span [2] - 326:36, 326:38 spare [1] - 292:9 speaking [8] - 277:18, 290:35, 291:44, 308:8, 330:38, 332:2, 355:8, 365:2 special [2] - 300:25, 313:9 specialised [5] - 328:17, 347:7, 347:18, 347:31, 348:14 specialist [10] - 264:14, 303:46,</p>	<p>304:47, 308:21, 308:26, 308:34, 312:20, 316:46, 318:28, 340:31 specialists [1] - 346:18 specialities [1] - 353:33 specific [15] - 272:5, 272:33, 278:39, 282:12, 283:32, 285:11, 285:22, 286:9, 288:26, 292:27, 299:17, 304:16, 311:31, 312:15, 359:12 specifically [8] - 277:15, 286:30, 289:30, 294:18, 304:47, 307:22, 312:23, 357:24 spectrum [3] - 304:26, 308:1, 348:3 speech [2] - 301:27, 350:11 spend [6] - 265:21, 309:44, 352:22, 352:41, 355:18, 364:5 spending [2] - 335:16, 359:32 spent [3] - 265:20, 335:19, 335:20 sphere [1] - 306:7 split [1] - 358:9 sporadic [4] - 281:46, 282:9, 282:10, 290:33 spread [2] - 314:9, 322:41 sprout [1] - 287:2 SSO [1] - 301:35 stabilise [1] - 270:25 stabilises [2] - 273:14, 273:27 stable [4] - 273:22, 318:41, 332:19, 348:39 staff [19] - 267:45, 274:34, 295:31, 295:32, 295:45, 296:13, 297:2, 297:4, 297:8, 297:16, 297:22, 297:29, 297:32, 298:3, 301:40, 310:23, 316:6, 358:11, 358:12 stage [23] - 266:10, 275:33, 277:24,</p>
--	---	--	---

<p>277:26, 322:35, 322:38, 322:44, 323:13, 323:25, 323:33, 323:35, 323:37, 324:12, 324:29, 330:28, 331:25, 332:44, 338:26, 341:6, 341:11, 341:12, 346:6, 347:18</p> <p>staged [11] - 322:20, 322:22, 322:26, 322:29, 323:5, 323:41, 324:11, 324:17, 324:27, 336:10, 339:35</p> <p>staged-linked [1] - 336:10</p> <p>stages [6] - 286:7, 323:31, 331:43, 333:13, 342:30, 346:44</p> <p>staging [5] - 322:29, 323:2, 332:43, 341:2, 341:14</p> <p>stagnant [1] - 353:24</p> <p>stakeholder [1] - 289:26</p> <p>stakeholder-led [1] - 289:26</p> <p>stakeholders [1] - 290:4</p> <p>stand [1] - 302:40</p> <p>standard [6] - 290:27, 340:15, 340:16, 340:18, 343:2, 346:3</p> <p>stands [1] - 302:41</p> <p>start [13] - 270:41, 271:16, 283:31, 289:23, 297:11, 302:38, 306:8, 309:25, 317:43, 322:20, 344:38, 345:44, 349:13</p> <p>started [10] - 265:18, 265:33, 299:5, 312:36, 336:16, 341:9, 344:42, 348:41, 350:19, 350:20</p> <p>starting [5] - 267:27, 272:6, 296:31, 318:13, 338:19</p> <p>State [1] - 343:4</p> <p>state [14] - 293:43, 302:27, 303:47, 306:2, 314:21, 314:46, 338:2, 338:6, 343:10, 349:8, 349:32,</p>	<p>355:33, 360:7</p> <p>state-wide [3] - 303:47, 306:2, 314:21</p> <p>statement [45] - 264:47, 265:4, 276:12, 276:15, 285:25, 291:22, 293:18, 293:21, 293:45, 296:39, 302:22, 302:26, 307:26, 308:13, 311:34, 312:25, 313:20, 314:32, 318:39, 319:43, 320:19, 320:31, 321:31, 321:36, 321:38, 322:21, 325:5, 333:35, 336:9, 337:37, 338:47, 339:8, 339:43, 339:47, 343:11, 344:11, 349:8, 350:9, 352:34, 356:28, 360:17, 361:35, 362:45, 364:16, 364:27</p> <p>statements [2] - 334:43, 337:42</p> <p>states [2] - 312:37, 360:4</p> <p>statistics [1] - 327:11</p> <p>status [1] - 358:4</p> <p>stay [6] - 270:9, 270:28, 273:22, 274:30, 352:8, 362:20</p> <p>stays [1] - 346:33</p> <p>step [12] - 272:16, 272:17, 272:20, 289:43, 289:44, 323:3, 327:28, 328:36, 341:25, 341:26, 344:31, 355:3</p> <p>steps [2] - 331:43, 335:44</p> <p>stereotype [1] - 363:26</p> <p>stick [1] - 333:20</p> <p>stigma [15] - 279:41, 280:3, 280:9, 284:41, 327:45, 328:1, 333:18, 333:23, 333:32, 354:10, 354:20, 362:32, 363:19, 363:47</p> <p>stigma's [1] - 354:13</p>	<p>stigmatisation [1] - 327:43</p> <p>stigmatised [2] - 333:14, 347:34</p> <p>stigmatising [1] - 333:26</p> <p>still [18] - 270:32, 271:28, 299:36, 300:28, 315:26, 324:33, 327:7, 327:27, 328:2, 330:40, 330:42, 344:8, 345:39, 346:34, 356:6, 361:24, 365:2</p> <p>stimulate [1] - 270:20</p> <p>stimulation [1] - 354:46</p> <p>stolen [1] - 350:11</p> <p>stomach [1] - 333:10</p> <p>stop [6] - 325:47, 335:24, 346:42, 357:20, 361:18, 361:19</p> <p>stopped [1] - 326:33</p> <p>stories [1] - 363:34</p> <p>straight [2] - 270:13, 289:44</p> <p>Strait [2] - 284:1, 284:47</p> <p>strange [1] - 350:13</p> <p>strategic [1] - 298:24</p> <p>strategies [4] - 297:17, 297:20, 336:41, 365:25</p> <p>strategy [1] - 335:13</p> <p>strayed [1] - 338:27</p> <p>Street [1] - 263:12</p> <p>strength [1] - 296:45</p> <p>strength-based [1] - 296:45</p> <p>strengthen [1] - 313:32</p> <p>strengthened [1] - 328:27</p> <p>strengths [3] - 296:43, 298:4, 298:9</p> <p>strengths-based [1] - 298:4</p> <p>stress [6] - 267:15, 267:25, 287:41, 292:33, 294:42, 305:26</p> <p>stressed [3] - 267:14, 267:17, 290:22</p> <p>stressful [1] - 278:31</p> <p>stressing [1] - 266:29</p> <p>stressors [3] - 272:28, 278:29, 278:32</p> <p>stretch [1] - 273:32</p>	<p>strict [1] - 318:24</p> <p>strictly [1] - 310:4</p> <p>strikes [1] - 356:10</p> <p>strong [8] - 297:13, 298:14, 328:23, 329:16, 344:36, 346:30, 351:5, 352:21</p> <p>strongest [1] - 329:22</p> <p>strongly [2] - 328:4, 337:8</p> <p>struck [1] - 341:38</p> <p>structural [2] - 307:12, 357:18</p> <p>structure [1] - 345:42</p> <p>structures [5] - 344:17, 348:17, 357:33, 358:13, 359:8</p> <p>structuring [1] - 323:17</p> <p>struggle [1] - 309:17</p> <p>struggled [1] - 328:39</p> <p>struggling [1] - 353:5</p> <p>student [7] - 296:11, 298:42, 301:25, 301:26, 301:29, 301:30, 301:43</p> <p>students [41] - 276:40, 293:28, 293:29, 293:32, 293:35, 293:40, 293:41, 293:42, 293:43, 294:10, 294:38, 294:42, 295:4, 295:8, 295:15, 295:28, 295:31, 296:17, 297:20, 297:25, 297:34, 298:8, 298:20, 298:31, 298:34, 298:37, 298:47, 299:7, 299:8, 299:9, 299:13, 299:16, 300:43, 301:1, 301:11, 301:13, 301:15, 301:20, 301:34</p> <p>students' [2] - 298:41, 299:19</p> <p>studies [6] - 288:10, 326:6, 330:31, 340:8, 353:47, 356:18</p> <p>study [6] - 271:15, 319:38, 335:3, 335:18, 336:6, 336:7</p> <p>studying [1] - 276:37</p> <p>stuff [4] - 269:25, 271:3, 274:44</p>	<p>style [1] - 346:34</p> <p>subacute [1] - 362:20</p> <p>subscribed [1] - 306:3</p> <p>subsidise [1] - 357:8</p> <p>subsidised [1] - 266:26</p> <p>subspecialty [3] - 277:8, 290:37, 290:38</p> <p>substance [5] - 284:30, 305:34, 319:12, 332:8, 337:18</p> <p>Substance [1] - 284:33</p> <p>substantially [3] - 339:31, 344:22, 356:14</p> <p>substantiated [1] - 319:6</p> <p>substrate [1] - 290:41</p> <p>subthreshold [1] - 338:3</p> <p>subtly [1] - 350:35</p> <p>subtype [1] - 363:29</p> <p>suburban [1] - 361:7</p> <p>suburbs [1] - 351:35</p> <p>success [3] - 299:38, 355:4, 363:46</p> <p>successful [1] - 363:41</p> <p>successfully [1] - 361:41</p> <p>sucked [1] - 266:34</p> <p>sudden [1] - 274:46</p> <p>suddenly [2] - 351:20, 351:21</p> <p>suffer [1] - 286:14</p> <p>suffered [3] - 304:42, 305:23, 305:32</p> <p>suffering [1] - 286:18</p> <p>sufficient [1] - 347:45</p> <p>suggest [2] - 360:33, 364:27</p> <p>suggesting [3] - 317:25, 337:44, 356:20</p> <p>suggestion [1] - 317:29</p> <p>suggests [1] - 293:35</p> <p>suicidal [5] - 266:37, 293:41, 301:1, 315:47, 350:36</p> <p>suicide [7] - 267:31, 268:12, 313:25, 318:44, 344:21, 349:28, 349:31</p> <p>suicides [1] - 350:2</p> <p>suitable [1] - 269:19</p> <p>suited [2] - 269:17,</p>
---	---	---	---	---

<p>275:5 summary [2] - 271:1, 282:4 sunk [1] - 353:2 sunshine [1] - 272:13 supermarket [1] - 335:19 supervised [1] - 346:15 supervision [1] - 312:30 supply [1] - 363:10 support [27] - 265:28, 265:31, 274:4, 274:12, 274:15, 275:19, 275:24, 275:31, 280:22, 291:46, 297:32, 301:14, 301:19, 301:26, 302:2, 312:28, 313:16, 313:44, 317:1, 317:2, 320:25, 323:27, 327:12, 327:14, 345:42, 360:9 Support [1] - 341:47 supportable [1] - 318:3 supported [5] - 309:38, 316:37, 353:41, 355:5, 365:31 supportive [4] - 274:6, 275:26, 354:3, 354:4 supports [4] - 275:27, 286:3, 286:4, 301:45 suppose [11] - 317:36, 324:20, 326:18, 341:41, 342:5, 357:47, 361:6, 362:20, 362:35, 363:1, 363:30 supposed [3] - 271:45, 330:3, 355:34 surge [1] - 329:18 surgery [1] - 322:39 Surgery [2] - 276:21, 302:29 surgical [1] - 305:28 surrounded [2] - 269:37, 275:6 survey [12] - 294:28, 294:30, 294:31, 294:37, 294:44, 299:32, 299:33, 300:42, 308:18, 327:6, 327:22, 327:24</p>	<p>surveys [1] - 326:29 survival [1] - 333:46 survive [2] - 273:19, 273:35 suspect [1] - 311:3 suspicion [1] - 335:38 suspicious [2] - 353:38, 353:39 sustain [1] - 324:3 sustainable [2] - 264:8, 312:30 Swanston [1] - 263:12 switch [1] - 342:43 sworn [1] - 321:28 symptomatic [1] - 320:37 symptoms [10] - 304:8, 305:12, 305:37, 307:44, 308:20, 323:38, 332:16, 332:24, 335:7, 338:3 system [102] - 264:36, 264:38, 272:6, 279:23, 280:30, 281:9, 282:44, 285:2, 290:41, 291:7, 292:40, 294:16, 306:47, 307:7, 307:29, 307:36, 308:15, 308:22, 308:33, 308:34, 310:17, 310:35, 311:11, 311:29, 311:32, 311:43, 312:17, 313:10, 314:6, 316:11, 317:29, 317:35, 317:38, 322:28, 323:30, 324:17, 327:32, 327:33, 327:36, 327:41, 328:44, 328:46, 329:15, 329:21, 329:26, 329:29, 329:36, 330:12, 330:18, 330:19, 330:20, 330:22, 330:23, 330:24, 330:32, 331:16, 331:19, 331:20, 331:29, 331:40, 331:42, 331:45, 334:18, 334:25, 334:26, 334:27, 341:21, 343:1, 344:1, 344:34, 344:35, 348:15, 348:24, 349:9, 349:17,</p>	<p>350:27, 350:31, 351:4, 351:14, 351:21, 351:40, 352:24, 352:25, 352:40, 352:44, 353:15, 353:21, 355:9, 356:31, 357:1, 357:11, 357:38, 357:44, 358:38, 359:14, 359:42, 359:45, 360:20, 361:41, 364:17 SYSTEM [1] - 263:5 system's [2] - 313:13, 353:2 systematic [2] - 309:6, 331:4 systems [10] - 331:13, 334:40, 338:40, 345:12, 345:20, 348:21, 352:47, 358:2, 358:35</p>	<p>329:12 teenagers [2] - 319:9, 319:20 teenagers/children [1] - 274:20 teens [3] - 325:27, 329:10, 329:25 telehealth [1] - 320:30 telephone [1] - 335:33 telepsychiatry [4] - 320:30, 320:36, 320:38, 320:43 tempted [1] - 357:1 ten [10] - 266:26, 273:30, 287:8, 328:6, 329:45, 334:20, 339:31, 353:26, 364:20, 364:34 tend [2] - 311:36, 337:19 tended [2] - 322:44, 333:11 tendency [1] - 337:4 tender [5] - 265:4, 276:15, 293:21, 302:26, 321:36 tends [1] - 315:45 tens [2] - 289:8, 364:5 tense [1] - 330:38 tension [2] - 315:12, 315:39 tensions [1] - 364:30 term [22] - 282:35, 291:41, 298:13, 299:6, 302:39, 303:16, 303:27, 305:14, 305:24, 309:33, 313:38, 326:12, 328:16, 338:20, 346:33, 363:1, 363:2, 364:26, 364:31, 364:38, 365:5, 365:12 termed [1] - 362:10 terms [50] - 266:44, 272:24, 272:42, 273:5, 273:6, 273:40, 276:27, 278:20, 278:36, 278:38, 280:33, 281:44, 282:26, 282:31, 282:34, 283:9, 287:29, 288:18, 288:35, 289:14, 289:35, 290:1, 290:14, 292:33, 293:31, 297:47, 300:45,</p>	<p>306:45, 307:5, 308:30, 309:23, 310:11, 311:7, 311:42, 314:15, 314:30, 318:45, 325:4, 329:18, 336:24, 338:39, 340:13, 348:37, 356:7, 361:47, 362:1, 363:41, 364:1, 364:15, 365:24 tertiary [5] - 283:11, 283:15, 290:23, 327:41, 343:4 testimonies [1] - 312:8 THE [6] - 276:4, 293:3, 302:13, 321:14, 365:40, 365:45 themselves [10] - 274:8, 274:16, 274:24, 274:25, 285:3, 292:6, 308:45, 316:25, 333:28, 344:2 therapeutic [5] - 346:8, 362:10, 362:13, 362:15, 362:47 therapies [4] - 269:34, 313:1, 334:22, 342:25 therapists [1] - 301:28 therapy [7] - 265:46, 266:20, 269:20, 269:22, 275:5, 336:35, 342:38 there'd [1] - 318:22 therefore [2] - 282:38, 307:28 they've [7] - 318:32, 332:15, 333:28, 334:1, 351:25, 352:37 thinking [16] - 277:5, 278:43, 279:25, 279:36, 292:38, 317:23, 325:25, 329:42, 335:2, 337:15, 342:23, 346:23, 346:37, 350:19, 359:4, 361:12 third [1] - 308:5 thoughts [3] - 266:37, 315:3, 363:3 thousand [1] - 343:27 thousands [1] - 343:17</p>
T		<p>tackle [1] - 329:34 tail [1] - 359:5 tailored [3] - 272:35, 341:45, 361:25 targeted [3] - 304:16, 304:43, 348:30 targets [1] - 311:27 task [1] - 290:19 tasked [1] - 317:1 tasks [1] - 325:36 teach [1] - 296:5 teacher [2] - 298:33, 301:33 teachers [2] - 301:17, 301:44 teaching [2] - 276:36 Team [1] - 305:2 team [5] - 302:45, 323:28, 335:34, 335:36, 364:26 team-based [2] - 302:45, 364:26 teams [7] - 343:40, 344:39, 344:40, 365:26, 365:27, 365:29, 365:31 tease [2] - 331:7, 339:8 technically [1] - 315:8 technique [1] - 342:32 techniques [1] - 342:33 teenage [2] - 268:9,</p>		

<p>threatening [3] - 344:5, 346:17, 352:4</p> <p>three [15] - 268:24, 268:27, 268:33, 270:29, 283:18, 285:32, 292:9, 303:42, 306:26, 307:27, 307:30, 308:13, 318:38, 344:41, 360:24</p> <p>threshold [4] - 280:28, 281:26, 328:20, 356:11</p> <p>thriving [1] - 273:20</p> <p>throat [1] - 333:9</p> <p>throughout [11] - 294:25, 295:22, 295:25, 296:6, 297:25, 298:19, 298:47, 299:5, 300:28, 300:36, 322:41</p> <p>throwing [1] - 281:21</p> <p>thrust [1] - 341:22</p> <p>tick [1] - 354:37</p> <p>tier [2] - 283:10, 340:33</p> <p>tiers [4] - 283:8, 283:18, 288:41, 289:36</p> <p>timetable [1] - 299:3</p> <p>timing [2] - 285:10, 319:24</p> <p>tiny [1] - 327:40</p> <p>TIPS [3] - 335:3, 336:6, 336:7</p> <p>TMS [13] - 270:18, 270:33, 270:40, 270:43, 271:17, 271:27, 271:29, 271:44, 271:46, 274:34, 354:42, 354:45, 355:4</p> <p>TO [1] - 365:45</p> <p>today [7] - 264:1, 264:11, 271:34, 300:9, 351:32, 364:18, 365:42</p> <p>together [7] - 288:14, 288:33, 295:2, 295:21, 296:27, 337:20, 347:44</p> <p>toll [1] - 349:28</p> <p>Tom [1] - 334:12</p> <p>tomorrow [1] - 271:28</p> <p>took [4] - 267:35, 271:9, 272:16, 335:44</p> <p>tools [1] - 281:36</p> <p>top [7] - 308:26,</p>	<p>325:11, 337:43, 345:33, 346:14, 363:5</p> <p>topic [6] - 264:2, 279:20, 279:28, 285:21, 333:22, 339:16</p> <p>topics [2] - 342:43, 349:6</p> <p>Torres [2] - 283:47, 284:46</p> <p>totally [5] - 327:21, 330:20, 356:4, 360:34, 362:31</p> <p>touch [1] - 292:5</p> <p>touched [8] - 272:44, 273:5, 273:43, 287:27, 308:40, 312:16, 316:31, 342:47</p> <p>towards [1] - 324:46</p> <p>town [2] - 265:38, 361:8</p> <p>Town [1] - 263:11</p> <p>toxic [1] - 363:30</p> <p>track [2] - 287:24, 291:35</p> <p>traction [1] - 328:40</p> <p>traditional [1] - 347:35</p> <p>traditionally [1] - 303:24</p> <p>tragic [2] - 291:31, 291:32</p> <p>train [2] - 284:2, 358:25</p> <p>trained [6] - 292:23, 292:35, 316:18, 330:19, 343:39</p> <p>trainees [1] - 276:39</p> <p>training [7] - 296:37, 305:43, 305:45, 306:1, 306:2, 306:3, 318:17</p> <p>transcranial [1] - 354:46</p> <p>transdiagnostic [1] - 339:17</p> <p>transdiagnostically [1] - 334:46</p> <p>transfer [1] - 348:22</p> <p>transform [2] - 334:33, 342:24</p> <p>transition [6] - 325:37, 325:45, 329:39, 330:32, 330:34, 338:6</p> <p>transitional [2] - 329:37, 331:23</p> <p>translated [1] - 353:34</p> <p>translation [1] -</p>	<p>314:38</p> <p>transplanted [1] - 328:46</p> <p>transport [2] - 266:47, 271:10</p> <p>trauma [3] - 284:21, 304:42, 305:24</p> <p>traumatic [1] - 305:37</p> <p>Travancore [1] - 304:14</p> <p>travel [1] - 320:44</p> <p>treading [1] - 340:26</p> <p>treat [2] - 349:31, 356:6</p> <p>treated [7] - 272:41, 287:24, 323:21, 324:28, 340:18, 341:11, 356:21</p> <p>treating [4] - 320:20, 331:36, 355:46, 356:2</p> <p>treatment [47] - 270:18, 270:33, 278:41, 278:46, 279:6, 279:13, 280:26, 281:44, 283:5, 283:19, 285:38, 286:13, 286:17, 287:15, 288:26, 288:35, 291:28, 306:31, 306:34, 306:35, 306:36, 313:1, 318:14, 322:45, 322:47, 323:4, 323:10, 323:14, 323:40, 324:3, 333:36, 335:13, 335:47, 336:20, 341:6, 341:10, 341:39, 341:41, 347:10, 353:22, 354:42, 355:17, 355:29, 355:35, 356:19, 365:24, 365:25</p> <p>treatments [24] - 278:37, 278:39, 279:3, 279:5, 279:8, 279:14, 282:13, 282:16, 285:37, 314:39, 316:19, 334:16, 334:21, 334:22, 334:23, 336:37, 336:44, 341:24, 341:31, 341:35, 342:7, 342:8, 347:18</p> <p>tremendous [1] - 354:36</p>	<p>trends [1] - 288:18</p> <p>triage [1] - 348:21</p> <p>triaged [1] - 346:29</p> <p>triaging [1] - 309:45</p> <p>trials [2] - 338:5, 338:33</p> <p>triangle [1] - 308:25</p> <p>trick [1] - 362:35</p> <p>tricky [2] - 299:36, 358:37</p> <p>tried [8] - 266:3, 329:34, 330:14, 331:31, 333:12, 363:4, 363:28, 363:30</p> <p>tries [1] - 281:11</p> <p>trip [1] - 267:7</p> <p>trouble [2] - 299:11, 345:11</p> <p>true [3] - 291:35, 305:9, 337:33</p> <p>trusted [1] - 328:24</p> <p>truth [2] - 359:35, 359:36</p> <p>try [13] - 265:28, 265:46, 266:2, 288:17, 302:21, 323:2, 341:18, 342:32, 349:10, 349:31, 352:26, 353:34, 361:8</p> <p>trying [16] - 266:39, 267:46, 272:17, 280:18, 295:41, 323:8, 331:28, 331:35, 337:14, 338:26, 339:25, 352:23, 355:2, 359:3, 359:42, 359:46</p> <p>turn [7] - 285:11, 286:40, 306:6, 309:20, 309:24, 324:35, 344:40</p> <p>turns [1] - 280:41</p> <p>TV [1] - 271:9</p> <p>twice [1] - 360:25</p> <p>two [36] - 267:7, 267:9, 268:41, 270:4, 270:30, 270:36, 270:42, 277:37, 280:21, 280:25, 287:33, 295:36, 298:18, 298:26, 303:35, 304:23, 306:3, 306:15, 308:9, 315:12, 329:35, 329:43, 330:3, 334:39, 335:6,</p>	<p>335:47, 337:1, 337:40, 337:42, 338:7, 339:32, 340:2, 343:7, 344:41, 349:36, 364:45</p> <p>two-day [1] - 306:3</p> <p>type [14] - 322:34, 330:29, 332:36, 337:37, 338:21, 345:42, 346:9, 346:41, 346:46, 347:35, 349:45, 360:44, 361:2, 365:28</p> <p>types [9] - 278:37, 293:31, 323:17, 341:45, 345:46, 346:2, 346:41, 347:3, 364:8</p> <p>typical [2] - 293:42, 301:37</p> <p>typically [6] - 301:13, 306:4, 307:3, 307:19, 312:7, 320:22</p>
U				
<p>Uber [1] - 271:39</p> <p>UK [5] - 319:18, 330:31, 342:14, 342:34, 359:27</p> <p>umbrella [5] - 296:17, 298:22, 298:28, 298:43, 338:20</p> <p>umbrellas [1] - 303:35</p> <p>unable [2] - 281:1, 308:9</p> <p>unborn [3] - 277:27, 279:7, 279:14</p> <p>under [12] - 270:23, 285:2, 296:17, 298:28, 304:45, 306:16, 315:38, 327:23, 329:9, 352:25, 357:33, 360:39</p> <p>under-resourcing [1] - 360:39</p> <p>under-serviced [1] - 304:45</p> <p>underestimate [2] - 291:38, 291:41</p> <p>underestimated [1] - 291:22</p> <p>underfunded [1] - 357:7</p> <p>underneath [1] -</p>				

<p>298:21 underpinning [1] - 356:31 underplaying [1] - 309:6 understood [1] - 345:2 undertreat [1] - 341:5 unfortunate [1] - 326:12 unfortunately [7] - 266:24, 267:16, 269:23, 271:31, 272:14, 273:1, 273:12 Uni [2] - 271:16, 271:43 unique [2] - 296:14, 297:30 unit [6] - 346:3, 346:8, 362:11, 362:47, 363:5, 364:19 units [8] - 306:12, 306:15, 346:14, 346:19, 346:22, 351:45, 352:7 universal [2] - 304:16, 323:37 universalism [1] - 310:32 universally [1] - 317:32 University [6] - 264:31, 294:29, 299:31, 321:43, 340:9, 340:38 unless [1] - 287:34 unrealised [1] - 349:16 unrecognised [1] - 318:30 unresolved [1] - 315:27 unstable [1] - 346:36 untreated [1] - 286:23 unviable [1] - 361:1 unwell [5] - 281:13, 289:4, 333:8, 335:12, 350:29 up [61] - 265:8, 266:3, 266:23, 266:33, 267:3, 267:7, 267:24, 267:31, 267:47, 268:16, 268:19, 269:10, 269:19, 270:24, 274:11, 274:17, 274:30, 274:36, 276:34, 277:18, 281:40, 285:1,</p>	<p>285:11, 286:29, 287:31, 288:10, 302:45, 302:46, 304:26, 306:41, 307:25, 309:3, 310:38, 315:16, 323:5, 324:21, 324:24, 324:29, 326:27, 328:41, 329:9, 329:32, 333:4, 336:18, 337:7, 337:19, 343:7, 344:7, 344:36, 344:39, 344:40, 344:41, 346:37, 346:46, 347:10, 347:33, 348:15, 359:42, 360:24, 365:4 UPON [1] - 321:23 upper [2] - 347:42, 348:27 upset [1] - 333:10 upstream [1] - 344:14 uptake [1] - 314:46 upwards [1] - 309:41 urgency [1] - 291:39 urgent [1] - 310:7 US [4] - 312:41, 339:33, 339:34, 339:35 useful [2] - 289:22, 313:43 uses [1] - 299:17</p>	<p>288:42, 288:43, 288:46, 303:6, 303:19, 306:15, 306:16, 306:27, 307:10, 310:29, 311:3, 311:4, 315:15, 319:45, 324:17, 329:45, 334:24, 336:39, 343:18, 343:28, 349:29, 350:31, 355:31, 356:41, 359:35, 360:5, 362:24, 364:39 Victoria's [2] - 322:28, 349:17 Victorian [4] - 283:41, 310:42, 343:23, 355:32 VICTORIA'S [1] - 263:5 view [21] - 276:47, 288:19, 288:20, 290:2, 304:10, 307:6, 307:12, 311:14, 314:2, 314:16, 318:6, 318:17, 319:39, 323:36, 329:15, 329:16, 336:14, 343:37, 345:16, 345:17, 358:40 views [2] - 349:7, 351:6 violence [2] - 284:18, 305:35 violent [2] - 285:3, 346:5 virtual [4] - 342:6, 342:10, 342:29, 342:37 virtually [1] - 364:6 vision [1] - 295:3 visit [4] - 268:43, 270:5, 289:45, 344:40 visual [2] - 287:5 vitals [1] - 267:41 vivo [1] - 342:21 vocational [3] - 325:38, 336:41, 341:46 vocationally [1] - 350:41 voice [7] - 308:38, 308:39, 308:41, 309:4, 312:12, 313:11, 316:29 volume [3] - 282:45, 331:32, 331:40</p>	<p>vomit [1] - 270:13 vulnerability [1] - 356:32 vulnerable [3] - 311:17, 311:24, 325:19</p>	<p>310:8, 336:1, 336:19, 352:22 welfare [3] - 310:23, 313:47, 356:22 wellbeing [39] - 277:32, 277:35, 288:36, 292:15, 292:16, 294:12, 294:24, 294:28, 295:4, 295:8, 295:14, 295:27, 295:29, 295:30, 295:32, 295:34, 295:37, 295:39, 295:44, 296:5, 296:11, 297:9, 297:18, 297:23, 297:24, 297:29, 297:32, 298:4, 298:14, 298:19, 298:23, 298:41, 299:10, 299:32, 300:31, 300:36, 301:12, 301:47, 308:19 west [1] - 365:18 Western [2] - 303:42, 315:29 western [2] - 306:27, 351:35 whatsoever [1] - 348:32 whereabouts [1] - 293:25 whereas [3] - 273:12, 329:2, 350:37 Whilst [1] - 296:23 whilst [1] - 300:27 who've [1] - 305:23 whole [27] - 273:32, 274:13, 278:15, 279:22, 287:14, 294:16, 297:40, 300:35, 301:2, 312:13, 314:46, 318:20, 326:36, 327:33, 329:20, 336:37, 341:4, 345:38, 346:20, 353:21, 355:22, 356:20, 356:23, 357:44, 359:17, 363:41 wholly [1] - 277:25 wide [5] - 299:16, 303:46, 303:47, 306:2, 314:21 widely [2] - 306:3, 320:31 wider [1] - 286:26</p>
	V		W	
	<p>validated [1] - 266:35 validity [1] - 318:16 valuable [1] - 312:13 value [1] - 365:19 valued [1] - 295:34 variable [3] - 311:3, 332:8, 355:20 varies [1] - 285:27 variety [2] - 299:8, 299:16 various [5] - 285:27, 289:36, 296:33, 316:14, 316:22 vast [2] - 306:23, 327:37 version [4] - 344:45, 349:2, 349:5 versions [1] - 346:13 vicious [1] - 267:17 Victoria [33] - 263:13, 265:9, 267:46, 279:47, 283:43,</p>		<p>Wadja [1] - 304:38 wagging [1] - 359:5 wait [5] - 267:4, 271:36, 271:41, 273:11, 323:4 waited [1] - 267:34 waiting [3] - 280:25, 309:31, 310:7 wake [1] - 287:31 Wales [3] - 317:12, 340:9, 340:38 ward [15] - 267:45, 268:1, 268:8, 268:11, 268:17, 268:20, 268:34, 269:14, 269:16, 269:17, 269:19, 306:21, 306:24, 306:30 wards [1] - 306:17 warning [2] - 337:38, 338:3 WAS [1] - 365:45 Washington [1] - 338:35 wasting [1] - 333:7 Water [1] - 299:6 water [2] - 330:30, 340:26 wave [3] - 351:11, 351:17, 351:38 ways [15] - 264:8, 288:7, 307:37, 315:17, 318:2, 329:35, 330:7, 331:24, 332:17, 332:34, 335:30, 342:40, 346:16, 348:3, 357:1 weak [1] - 329:21 weakest [1] - 329:22 week [9] - 269:29, 270:13, 271:41, 271:43, 275:35, 276:31, 287:33, 296:8, 301:39 weekend [1] - 268:43 weekends [1] - 270:5 weeks [7] - 270:35, 280:21, 280:25,</p>	

<p>widespread [3] - 305:44, 335:15, 339:36</p> <p>willing [1] - 328:10</p> <p>wilted [1] - 358:27</p> <p>wing [1] - 357:33</p> <p>wiring [3] - 286:47, 287:2</p> <p>wished [1] - 330:35</p> <p>WIT.0001.0005.0001 [1] - 265:4</p> <p>WIT.0001.0023.0001 [1] - 321:36</p> <p>WIT.0002.0005.0001 [1] - 276:15</p> <p>WIT.0002.0006.0001 [1] - 282:26</p> <p>WIT.0003.0009.0007 [1] - 293:21</p> <p>withdrawn [1] - 265:18</p> <p>WITHDREW [5] - 276:4, 293:3, 302:13, 321:14, 365:40</p> <p>withdrew [1] - 265:18</p> <p>WITNESS [5] - 293:3, 302:13, 321:14, 365:40</p> <p>witness [11] - 264:40, 276:6, 290:36, 293:12, 302:9, 302:15, 312:24, 321:17, 362:45, 364:16, 364:26</p> <p>witnesses [1] - 264:11</p> <p>woman [9] - 264:12, 280:15, 281:8, 282:24, 283:21, 285:34, 286:2, 288:31, 289:4</p> <p>woman's [4] - 277:3, 277:16, 279:12, 282:44</p> <p>women [48] - 277:2, 277:4, 277:5, 279:25, 279:35, 279:40, 279:42, 280:3, 280:7, 280:15, 280:45, 283:24, 283:29, 283:44, 283:45, 283:46, 283:47, 284:1, 284:2, 284:5, 284:7, 284:8, 284:15, 284:17, 284:26, 284:27, 284:29, 284:36, 284:43, 284:44, 284:46, 284:47,</p>	<p>285:1, 285:4, 285:15, 285:43, 286:14, 287:37, 288:44, 289:13, 289:24, 291:5, 292:10, 292:28, 326:44</p> <p>wonder [1] - 319:26</p> <p>wonderful [2] - 350:18, 365:30</p> <p>wondering [1] - 299:28</p> <p>word [4] - 319:9, 333:39, 360:30, 363:26</p> <p>words [5] - 286:44, 286:45, 342:10, 344:24, 351:12</p> <p>worker [2] - 268:4, 268:6</p> <p>workers [2] - 313:16, 361:44</p> <p>workforce [3] - 314:8, 314:16, 361:33</p> <p>works [3] - 282:2, 333:25, 348:8</p> <p>World [2] - 347:21, 359:23</p> <p>world [12] - 287:21, 305:20, 328:39, 336:39, 338:13, 342:33, 354:32, 355:17, 355:18, 355:22, 359:22, 360:3</p> <p>world-leading [1] - 305:20</p> <p>worldwide [1] - 281:36</p> <p>worried [1] - 352:37</p> <p>worry [1] - 266:27</p> <p>worse [8] - 281:4, 323:6, 333:11, 344:8, 349:24, 353:28, 363:21</p> <p>worsened [2] - 324:30, 324:32</p> <p>worsening [1] - 294:42</p> <p>worst [2] - 291:31, 325:13</p> <p>woven [2] - 277:10, 290:40</p> <p>writer [1] - 350:12</p> <p>writing [1] - 352:42</p> <p style="text-align: center;">Y</p> <p>yard [1] - 299:12</p>	<p>Yarra [1] - 263:11</p> <p>Year [5] - 267:24, 270:42, 294:38, 299:2, 301:3</p> <p>year [21] - 269:32, 273:32, 283:23, 287:8, 297:45, 306:3, 309:15, 319:7, 326:38, 327:23, 331:36, 335:6, 338:7, 339:28, 344:45, 349:29, 349:32, 349:33, 349:36, 349:43, 355:15</p> <p>years [58] - 265:5, 266:4, 270:42, 277:3, 299:37, 300:44, 301:3, 301:4, 301:8, 303:18, 303:20, 303:38, 304:27, 304:34, 305:6, 308:10, 312:36, 313:24, 315:6, 315:15, 324:38, 326:30, 328:6, 329:12, 329:45, 330:23, 331:34, 332:11, 335:5, 335:47, 336:11, 336:28, 337:1, 337:2, 337:15, 337:40, 338:8, 339:26, 339:32, 344:47, 345:36, 347:25, 347:43, 348:5, 349:35, 349:42, 352:36, 353:3, 353:26, 355:6, 356:11, 356:12, 357:7, 359:36, 364:45, 365:4, 365:19</p> <p>yesterday [4] - 264:5, 300:3, 324:36, 359:19</p> <p>Yesterday [1] - 300:1</p> <p>young [76] - 264:12, 264:27, 269:29, 272:27, 272:35, 274:20, 275:3, 275:4, 275:39, 277:6, 280:9, 294:25, 301:47, 303:20, 303:23, 303:38, 304:7, 306:23, 306:29, 307:38, 308:30, 315:37, 315:44,</p>	<p>316:12, 316:25, 318:25, 318:28, 319:28, 319:32, 320:4, 320:27, 324:35, 325:3, 325:5, 325:18, 325:34, 325:43, 326:1, 326:3, 326:15, 326:18, 326:25, 326:35, 326:43, 326:44, 327:8, 327:19, 327:31, 327:37, 327:40, 327:46, 327:47, 328:1, 328:4, 328:19, 329:12, 330:9, 332:7, 332:12, 333:23, 333:27, 335:34, 339:4, 339:12, 339:14, 339:44, 340:41, 340:44, 341:22, 349:35, 351:34, 353:47, 356:11, 362:2, 363:40</p> <p>younger [7] - 316:13, 330:13, 345:40, 346:45, 348:26, 363:18, 363:23</p> <p>yourself [3] - 264:45, 273:15, 278:16</p> <p>youth [42] - 264:25, 264:30, 272:33, 275:21, 294:27, 299:32, 303:18, 303:28, 306:16, 306:31, 310:42, 313:15, 313:25, 315:1, 315:4, 315:14, 315:16, 315:39, 316:11, 317:21, 327:11, 328:31, 329:33, 329:40, 329:41, 329:42, 331:35, 334:46, 340:42, 340:43, 340:44, 341:19, 345:47, 346:13, 348:38, 359:28, 360:29, 361:40, 361:44, 361:46, 362:2</p> <p>Youth [9] - 264:32, 306:25, 314:35, 321:42, 321:47, 322:4, 322:13, 349:32, 359:24</p> <p>youth-centred [1] - 275:21</p>	<p>youth-focused [1] - 275:21</p> <p>youth-friendly [1] - 340:44</p> <p>youth-specific [1] - 272:33</p> <p>Yung [1] - 337:47</p> <p style="text-align: center;">Z</p> <p>zero [1] - 315:11</p> <p>zone [3] - 329:37, 330:4, 331:23</p> <p>zones [2] - 330:3, 348:2</p>
---	--	---	--	--