Submission No 2

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Name: Mr Marc Lamond

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To Dr Amanda Cohn and fellow members of the committee,

My name is Marc Lamond; I am a registered nurse, working in the NSW Health system. I have been a mental health nurse since 2015, and, have almost exclusively worked in the community mental health setting. I am currently employed as a Clinical Nurse Consultant within the SLHD, working in an adult mental health case management team (AKA Care coordination). I request that my name, role, and personal details be withheld from the public – This is in order to protect my employment within the NSW Health and SLHD.

Below, I submit a report I conducted into evidence based literature pertaining to long term community mental health supports, and disparages between current practices. I'm trying to provide you with as an objective account as possible, so, I've limited providing my own anecdotal experiences as much as possible. I am very passionate about providing mental health care, particularly in the community setting. I firmly believe that far more funding should be provided to community mental health support, especially the public sector / NSW Health / Primary Health Network, in order take preventative measures within our service, akin to primary health care; rather than crisis, risk based care provided presently.

Caseload/workload in Adult Community Mental Health Case Management: A Review of the evidence

Since the deinstitutionalisation of mental health care and consumers in the 1960's, care coordination and community mental health treatment had become increasing important – leading to an influx in the employment of community mental health clinicians (Happell et al, 2012; Jones et al, 2018; Willis et al, 2012). With a larger focus of community mental health treatment, additional support by non-government organisations, and funding for ambulatory care increased, multidisciplinary mental health teams have been developed (Happell et al, 2012; Jones et al, 2018). In contemporary mental health, community mental health has become the primary focus of care delivery, especially with recent trends towards shorter inpatient admissions and earlier discharges – Leading to a significant increase in the workloads of community mental health clinicians (Happell et al, 2012). The 1993 Burdekin Report, in which there were recommendations that governments improve the provision of service alongside the Non-government organisation (NGO) sector, and dramatically increase the funding and resources to these services. The extent of the funding varies wildly between states of Australia. The recovery and rehabilitation focused aspects of community mental healthcare are now the work of these NGO's (Bender, 2013). As community mental health services become more important, the primary service delivery model, and being further disconnected from inpatient services (in terms of methods of service delivery); the role of the support worker becomes much more autonomous, and important (Procter et al, 2016).

The concept of case management is a way to ensure that consumers have access to whatever services are needed; this access must be provided in a "coordinated, effective, and efficient manner." Case management aims to provide continuity of care longitudinally, with the ability to be responsive to changes in a person's needs. Long term continuity of care among our cohort of consumers is particularly relevant, given the lifelong nature of chronic mental illness (Intagliata, 1982). Caseloads of care coordinators in the community mental health setting vary wildly among different among different countries (King, 2009). In the UK for example, mental health nurses are the dominate discipline employed in the community setting, whereas in the US, social workers are more prevalently employed in the same position/setting. The introduction of "support workers" alongside mental health clinicians in the UK have been implemented, and focus on promoting recovery (Happell et al, 2012). A strong understanding of workload, current practices, and consumer need is essential in tailoring services to ensure that safe and effective care is being delivered; this is particularly poignant in our current world of expanding service need and evaporating resources (Happell et al, 2012).

The Broker model was the earliest form of care coordination. Its focus was on the assessment of consumer need, linking them into an appropriate service pathway, then review and evaluation of consumer outcomes (Happell et al, 2012). Rehabilitative care coordination incorporates aspects of the Broker model of care coordination, alongside psychiatric rehabilitation – Goal setting, functional assessment and education; in order to improve the functionality of consumers in their own home/environment. The assertive community treatment model of care coordination involves supporting

consumers to maintain community living. This is achieved through – Obtaining and maintaining basic resources, such as food and shelter; teaching the skills of daily living; assist and support with problem solving within the community; encouraging autonomy and independence; education and support of carers; and being assertively involved in the care of the consumer. Intensive care coordination is very similar to the assertive model of care, with the main difference being caseloads are not shared in the intensive model, as they are in the assertive model (Happell et al, 2012). Opinions differ in regards to what the essential elements of each model of care should be, as well as limitations in what can be provided due to resources. What is noted is that the assertive and intensive models of care require greater outreach to consumers, increased frequency of contact, higher levels of service provision, smaller caseloads, and highly skilled staff. The assertive and intensive models care have recently been considered to have a better efficacy than the "standard" models of care, with improved service contact and lowered "lost to care" rates; reduced lengths of hospitalisation, and greater numbers of consumers living in independent circumstances. Of interest, is when looking at the numbers of consumer death, incarceration and employment, there is no significant difference between assertive, intensive and "standard" models of care (Happell et al, 2012; Procter et al, 2016).

There is literature to suggest that community mental health teams have experienced excessive workloads, high levels of stress, and significant clinician burnout for over 20 years. This leads to reduced job satisfaction, recruitment and retention challenges, and negatively impact the health and wellbeing of the care coordinator. (O'Neal et al, 2022; Procter et al, 2016; Van Hippel, 2019). One in five healthcare workers experience signs and symptoms of PTSD. Post-traumatic risk factors include low social support in work setting, unsafe working conditions, heavy workload, passive coping, anxiety and burnout (Sharplin et al, 2023). Staffing shortages are directly impacting the implementation of safe and effective patient care (Fanneran et al, 2015). Care planning, carer support, and liaison with other care providers are neglected once workloads and caseloads increase. Essentially, when care coordinators are faced with excessive caseloads, their focus becomes crisis management and addressing immediate problems, reducing meaningful and recovery orientated engagement with consumers and carers (O'Neal et al, 2022; King, 2009). Research suggests that ever increasing workloads of the community mental health clinician, and subsequent time pressures associated with implementing treatment under high workloads, limits the quality of therapeutic interventions (O'Neal et al, 2022). Happell et al (2012) put it bluntly – "With Australian mental health nurses also having heavy workloads, it stands to reason that consumers in this country are not receiving interventions that could enhance their lives."

Case management *should* be a community based point of contact, to access services. Within this, the service itself would provide crisis management, assessment, psychotherapy, counselling, psychoeducation, building and monitoring activities of daily living; psychosocial functioning, medication monitoring, and liaison with other support networks to facilitate the consumer to access a much broader range of services within the community. This is consistent with previous studies conducted in Australia (King et al, 2004).

Caseload: A numbers game?

Think of a classroom – Classroom limits of 30 (something we don't have), one teacher. Of the 30 students, 20 a ready, willing and able to learn – They want to learn, and graduate. 5 students want the same, but require intensive support from their teacher, due to a higher degree of complexity. The remaining 5 want nothing to do with the classroom, they find this method of teaching excruciating and does not suit them. The 5 students that aren't interested are bound by legislation to attend school; they often disrupt the class, requiring repeated interventions by the teacher to have them engage in the class. Sure, there are classes that are tailored to the 10 students that require more support; special education classes for example. However, they have smaller limits due to intensity, and therefore, smaller capacity. Many of the students that require intensive support or different learning environments remain in the "regular" class due to limited capacity. The teacher in the regular class spends more time with 10 students, while the 20 that are willing to learn and engage have their learning experience limited.

Working in the community mental health setting; this speaks so much to my experiences with adult case management, as well as many of my colleagues. We simply do not have the time, resources, funding, or staff to provide equitable and comprehensive health care.

The current model of care for adult community case management services here at Sydney Local Health District (SLHD, 2020) highlights a “limit” of 30 and “maximum” of 35. When management were asked about where the numbers were drawn from, they cited the seminal article by Intagliata (1982). While seminal, it should be noted that contemporary mental health services differ dramatically to that of 40 years ago. Similarly, without context, the numbers are truly telling the whole story. Intagliata (1982) also suggests that - Numbers should consider the model of care being implemented; caseloads should be set conservatively low at first, gradually increasing numbers while monitoring the consequences of doing so; and decisions to set fixed caseload sizes should be made in a rational manner, using empirical evidence. It has been suggested that caseloads of 40 – 50 *may* be acceptable, if the goal of care coordination is crisis management, not comprehensive care (Happell et al, 2012; Intagliata, 1982). Studies have equated average caseloads of adult community mental health services to 35 – 40 consumers, and have highlighted that caseloads have increased over time – caseload sizes have increased by 50% in the eight years spanning 1992 – 2000 (Happell et al, 2012). With a worldwide mental health staffing shortage, one can only assume that caseloads have continued one that trajectory from 2000 – 2023 (Fanneran et al, 2015). So, presently, our case manager is now working caseloads in excess of 35 – 40 consumers; we are effectively providing reactive, crisis driven treatment to our consumers. Early studies suggest that caseloads in excess of 20, and/or 30 consumers, result in “reactive” case management (Intagliata, 1982; King, 2009).

Despite numbers suggesting caseloads between 10 and 30 consumers to be in range appropriate for comprehensive care, many caseloads are significantly larger (King, 2009). Think back to the classroom metaphor: around 13 of the 40 are receiving the vast majority of the case manager’s attention: They have complex needs, they are under coercive treatment and require assertive follow up, or most likely, are both. The other 27? Minimal support. This is theoretically an entire caseload receiving minimal support. Don’t forget, the “special classes;” assertive outreach, early intervention psychosis teams are at capacity and cannot work with the 13 (they may not meet criteria anyway). This is highlighted by Bender (2013), who reviewed the workload intensity between an adult case management team and a specialist assertive outreach team in terms of client complexity, time spent with clientele, and liaison activity. The study found there was no significant difference between either team. It concludes that the adult case management teams, even with NGO support, is unlikely to meet the need of the consumer base. There is evidence to suggest that there is no significant difference in consumer outcomes with the intensive model (<20 consumers per clinician) and “regular” models of care (>20). This was concluded by measuring data surrounding re-hospitalisation rates, cost, behaviour, consumer satisfaction, mortality, mental state, service usage, social functioning, and quality of life (Happell et al, 2012; Procter et al, 2016).

In comparison with care coordinators with lower caseloads, the cohorts with high caseloads were less likely to have an understanding of aspects of a consumers biopsychosocial standing – For example, familiarity of the consumer’s home environment. Care coordinators with high caseloads were also less inclined to keep in contact with hospitalised consumers, which directly impacts continuity and overall care provided (Happell et al, 2012). You can see, that higher caseloads has a dramatic impact on holistic care we tout as providing. One aspect not captured in the literature that I’ve experienced anecdotally – Decreased capacity to follow up consumers, resulting in an increase in referrals to crisis management services. Compounding all of this, is the fact that heavy workloads and more administrative tasking are now the large focus of their role, leading to a reduction in the time they have to engage in care of their consumers (Happell et al, 2012). The administrative aspect of care coordinator workload is ever expanding and has a profound negative impact on the time spent with consumers. Research from the UK has highlighted that the average care coordinator spends less than 25% of their working hours in direct contact with their consumers (Jacobs et al, 2006; Simpson, 2005). In our current practice, is that we must meet KPI’s they ask that we spend 60% of our worktime in direct contact/care of our consumers. As suggested in the UK study, this is seemingly impossible, yet this KPI is directly linked to our funding and profoundly important.

Overall, there is minimal empirical evidence in the domains of caseload and/or workload in the community mental health setting. What research that has been conducted has been considered poor. What this highlights is that current policy and procedures developed by our administrators are only loosely based on actual evidence (Happell et al, 2012). Reducing caseloads numerically will not

completely resolve the issues with workload (O'Neal et al, 2022). Evidence-based staffing and workload management is essential in the contemporary mental health nursing field, particularly looking into the future (Fannerran et al, 2015). A number of papers (Happell et al, 2012; King et al, 2004; O'Neal et al, 2022) suggest there are seven variables when determining a caseload measurement tool – Contact frequency, response difficulty, type of intervention, competence of clinician, maturity of caseload, geographical considerations, and roles outside of care coordination.

Contact frequency:

Contact frequency can be used as a tool to measure service demand. Presently, it is easy to measure, given it is already measured electronically and accessible. Further, it is a quantitative measurement, which can be correlated alongside other measures. The frequency of contact offers a reasonable insight into the experiences of care coordinators. With that said, there are limitations and disadvantages to this form of measurement – Frequency of contact is not always indicative of workload; in order to determine an accurate caseload, we must also consider the quality and duration of contact. Additionally, we must consider the volume of follow up work required after a service contact, including psychological stress/burden following a difficult service contact (Happell et al, 2012; King et al, 2004). We already compile large amounts of data relating to contact frequency via activity based client activity. Yes, there are some limitations, but it would be a good starting point in measuring service demand.

Client needs and response difficulty:

Measurement of consumer need offers an understanding of the service demand for each individual consumer. It is a quantitative measure, which can be facilitated by use of a standardised checklist – This check list considers service engagement, level of risk, amount of family/social supports, and symptom severity. Difficulty of response takes into consideration a number of factors affecting challenges implementing care – Difficulty with service engagement, aggression, multiple diagnoses, and suicidality. Using this method, caseloads are viewed by the total number of consumers and "difficulty scores" rather than pure caseload numbers. Response difficulty essentially measures the complexity of each individual consumer's presentation, and service requirements (Happell et al, 2012; King et al, 2004). Limitations to these approaches – High consumer need and/or difficulty in response does not always equate to increased workload. For example, some factors associated with difficulty in response, may render a response impossible i.e. high levels of aggressive behaviour, engagement. Alternatively, a high service demand, or high difficulty in response may be undertaken by another agency i.e. Acute Care Service. The other major limitation is the fluidity of service demand and difficulty in response. This may fluctuate on a weekly basis and would not necessarily be taken into account until a review of care is undertaken (Happell et al, 2012; King et al, 2004). There is literature that is not referenced in this report which speaks to the use of "traffic light" systems to rate client needs and response difficulty. With a traffic light system already built into eMR, this is could be achieved. Utilising the senior clinicians' roles, monthly caseload reviews, alongside HoNOS, LSP scores, and upkeep of the traffic light system, accurate measurement of client needs and response difficulty is possible with little change to current practices.

Intervention type:

Care coordinators provide a wide range of evidenced-based interventions, aimed to improve the consumers' quality of life – this includes improving activities of daily living, family/care psychoeducation, and psychotherapy. As expected, different therapeutic interventions require varying timeframes and demands in order to implement. Therefore, it could be a significant consideration when reviewing a caseload. More labour intensive interventions, such as individual psychotherapy, will increase the workload of a clinician, compared to other interventions (Happell et al, 2012; King et al, 2004). Limitations to this approach – For this method to work effectively, there is an assumption that the most cost effective and clinically effective therapeutic intervention is offered by the care coordinator. Essentially, it is possible that a care coordinator will offer a more time intensive therapeutic approach, where it is possibly not indicated, in order to maintain a reduction in workload (Happell et al, 2012; King et al, 2004). This could also be considered during monthly caseload reviews, with a discussion of each individual care coordinator's additional duties.

Care coordinator competence:

In order to measure the competency of the care coordinator, we have to assume that care coordinators are not equal, and their effectiveness is matched by their different skill levels. This would impact their effective caseload. However, there are no standard measurement tools to obtain data in this realm, and it has been argued that experience does not always equal efficiency. It has been suggested that more senior clinicians should manager higher caseloads than their colleagues with limited experience, however this is based on a moral argument, rather than evidence (Happell et al, 2012; King et al, 2004). Anecdotally, it could be argued that senior clinicians having a smaller caseload have more time to supervise and support junior clinicians with their caseloads.

My personal experience with case management as a junior clinician, and now a senior, I have experienced or witnessed significant stress, burnout, distress, and anxiety associated with our positions. I myself had cried numerous times as a junior member of staff, stressed, overwhelmed, with little to no support. Similarly, now as a senior clinicians have disclosed to me the amount of stress, anxiety and tears shed in the workplace as a result of: Limited support, excessive workload, a steep learning curve. Community mental health case management is a highly autonomous role, with a high level of accountability, burdening staff with psychological stress.

Case load maturity:

Anecdotally, many care coordinators have reported that the burden of workload is far higher during the initial referral process, rather than consumers who have already established longer term relationships with their care coordinator. This is supported by ongoing analysis of the tasks involved in care coordination. During the initial phase of care, a care coordinator is expected to establish rapport and develop a therapeutic relationship with the service, including consumer and relevant stakeholders. Alongside this, a care coordinator would conduct a complete biopsychosocial assessment, then begin recovery orientated goal setting, external referral, and care planning. In contrast, the care coordinator providing care to a well-established consumer, maintain the relationship, and review care plans laid out in the initial phases. It should be acknowledged that long term consumers will have periods of increased and intense phases of care, including crisis. However, overall, the well-established consumer does not require the amount of support and input that a consumer entering a new phase of care requires (Happell et al, 2012; King et al, 2004). With that said, unfortunately there is no empirical evidence to support that caseload maturity affects workload. This is largely due to the number of variables, and changes to intervention type among consumers (i.e. ongoing movement from functional gain to intensive extended). Generally however, it has been accepted that newer staff should have smaller caseloads than well-established staff (Happell et al, 2012; King et al, 2004).

Geographical distribution of clients:

It has been noted that if consumers are to be home visited, that the location and time taken to travel to their residence should be considered when assessing caseload capacity. Again, there is little empirical evidence to quantify this, as it is difficult to measure. Further, it is mostly applicable to regional and remote areas, requiring significant travel times (Happell et al, 2012; King et al, 2004). We are blessed in this district with small catchment areas, and this is not generally a consideration of our practice. However, it should be a strong consideration in remote and regional areas when making adjustments for staffing.

Care coordinator roles outside of care coordination:

Care coordinators generally undertake a number of roles outside of their duties as care coordinator. Other roles can include education, development, supervision, and specialist clinical services – psychotherapy, medication administration, and mental status examination. It is often not possible to clarify the boundaries between care coordination duties and the roles undertaken outside of them, however it cannot be assumed that all care coordinators share the non-care coordinator roles equally. Given the inequity, it is rather important that we determine how much time each individual care coordinator can offer to provide effective care coordination. Team leaders, should be able to determine this in consultation with each individual clinician. Previous studies have suggested that the Team leader can ask care coordinators report the hours they have available, however it comes with the caveat that

clinicians cannot always reliably offer an accurate estimate (Happell et al, 2012; King et al, 2004). Again, this can be taken into consideration when reviewing a clinician's caseload on a monthly basis, and redistributing workload as required; this may be a permanent or temporary redistribution. The main challenge with this presently, is that the Team leader simply does not have the time to quantify this. Using my current workplace as an example, our team consists of 13 full time equivalent staff, one team leader, and a fluctuating consumer base of 300 – 400 clientele. It is essentially impossible for a Team leader to review the needs of these consumers alongside this many staff, every 4 weeks. This exacerbates the already highly autonomous environment, and sadly, leads to poor outcomes in client care (in my opinion).

Measuring caseloads within an individual team, in an accurate manner, has others benefits: equality. Fair and equitable distribution of workload throughout the multidisciplinary team is important, with potential relevance to staff efficiency and performance. There needs to be a rational manner that new referrals are allocated, in order to equally distribute workload. Effective caseload management has the capacity to influence public policy, standards of service provision, consumer satisfaction, staff satisfaction, cohesiveness of the multidisciplinary team, and affect total service cost (Happell, et al 2012; King et al, 2004). Similarly, it helps provide consumers equitable access to health care, as well as more comprehensive and holistic care planning.

Effectively measuring caseload and workload

Currently, the burden of this complex and timely task is weighed upon the team leader of the case management Teams, shared with the care coordinator themselves. The discussions above had determined that this is not a reasonable or practical approach. The literature defines this approach as the "Queensland model." Developed by the University of Queensland, this model essentially relies on the Team leader assess workload, efficiency, and productivity – Then distribute workload equally across the team. It does not consider contact frequency, rather uses fair distribution to provide equity. The Team leader will be accountable for each case manager to have equivalent level of high, medium and low contact consumers in their caseload – This requires an assignment of a "response difficulty rating" at the time of client review. The Team leader is to consider geographical location, non-case management roles of the case manager, maturity of caseload and seniority of the case manager when decision making. This model does place a burden on the Team leader to continuously and consistently evaluate the caseloads of their staff, however offers the positives of clear and effective communication and clinical supervision directly with staff and manager (Happell et al, 2012; King et al, 2004). Allocations of consumers and caseloads by Team Leaders is reasonable and effective among a small case management service. Once caseloads and consumer bases increase, it becomes far more difficult for one person to know and understand each care coordinator's caseload, and, fairly allocate work according to size and complexity (Korasz et al, 2018). Essentially, this method works fine in small speciality teams like Older person mental health care and the Early intervention in psychosis teams; but is far too simplified for larger teams such as Assertive outreach and adult community mental health case management teams.

The Melbourne Model:

This model is structured around the use of consumer activity data, and utilises this data in order to achieve equitable workloads. All Victorian service providers are required to collect client contact activity data, including telephone contact. All data is logged in a database, which includes date, duration, location, and other people involved in the contact. This data is then analysed, and three clear patterns of service provision were identified – High, medium, and low contact frequency. The high contact group accounted for 8 times the input of a typical client considered low contact (Happell et al, 2012; King et al, 2004). This approach could be easily implemented alongside regular caseload reviews, with the utilisation of client activity data. The barriers to utilising this approach are previously discussed above, under the "contact frequency" subheading – Namely, under/over reporting of activity data by care coordinators, not entirely reflective of workload.

The Caseload Index Approach:

This is essentially a computer program, designed to support caseload management strategies. The program consists of a "response difficulty measure" (I'm assuming in relation to the consumer), and an "approach." This approach has two categories – Maintenance and intensive/extended. This takes into consideration treatment goals and severity of symptoms. It also factors in the challenges surrounding follow up with a consumer, and treatment refractory cases. This then provides a "case weight" and estimation of the required clinical time for each coordinator on a weekly basis (Happell et al, 2012; King et al, 2004). I am unsure if we have the required resources to undertake something akin to this. Further, any additional software would ultimately be expensive.

In recent times, O'Neal et al (2022) has suggested that essentially a mixture of analytical and contextual approaches may be the best solution to addressing caseload/workload balance. The analytical begins with reviewing the number of hours required to complete non-clinical responsibilities – Training, administrative duties, education etc. Then, determining how many hours are approximately spent on each consumer and their carers. Non-clinical hours are divided by hours required per case, to determine rough caseload numbers. With this information, you can roughly determine staff FTE. This method works on the assumption that the current level of care measured is appropriate, preferred by consumers, and of a high quality. The contextual approach, involves utilising the 7 domains discussed above – Contact frequency, response difficulty, intervention type, staff experience, caseload maturity, geographical logistics, workload outside of caseload.

O'Neal et al (2022) suggests utilising both in tandem, to achieve approximations of staffing requirements of a specific health centre. It integrates the "context rich" approach into the "maths approach. This can be adjusted an utilised across health centres and services, accounting for variations within each service.

"Integrated" approach:

- Determine how many hours are available service wide for care coordinators to service consumers, subtracting the hours spent on non-clinical tasks previously mentioned.
- Determine average contact frequency per client, per year – Average contact frequency x total number of clientele.
- Response difficulty & Intervention type: Can be broken down into "high, medium, low (2, 1.5 and 1)" for both response difficulty and intervention type. For our purposes, we could utilise either the traffic light system, or focus of care on Health of the Nation Outcome Scales (HoNOS) or one for each respectively.
- Staff seniority: Develop and expected number of extra hours that would be required for new staff in their first year within the role, and quantify it in a number of hours.
- Caseload maturity: Determine the amount of extra hours required to service new clients, then times by average number of new clients per year.
- Geographical location: Determine hours required to travel for home visits, other centres, hospitals etc. (O'Neal et al, 2022).

Additional responsibilities: Account for number of hours spent on activities that are not related directly to care coordination. Total hours of contact frequency, response difficulty, intervention type, staff seniority, caseload maturity and geographical location – Divided by – available hours for care coordinators to service consumers (O'Neal et al, 2022).

Care coordination is a fundamental aspect of community mental health service provision. It has become extremely important in providing the least restrictive form of care, in the least restrictive environment. In modern times, care coordination has become complex; with consumers requiring higher needs, and non-clinical time stretched between growing administrative tasks, and liaison with growing stakeholders – NDIS, support coordinators, GP's, carers, and NGO's. With worldwide staffing problems, workloads and caseloads continue to grow within community mental health teams. Discussed was the current model of care at my workplace, relevant literature, and possibilities for caseload management moving forward. It is clear that the current model of care here in SLHD does not meet the needs of service demand, and needs a significant overhaul. I propose that this would be the case across NSW Health network as a whole, given the amount of additional funding and resources our district would hasve

compared to other parts of NSW. Included in the overhaul, is making significant changes to how caseload and workload among care coordinators in community mental health teams are reviewed and implemented; with a special focus on adult case management teams. Recent literature suggests a blended model of analytical and contextual approaches, to achieve this. O'Neal et al (2022) paper suggests that this is achievable – With 8 years of clinical experience in an adult community mental health team, I am of the opinion that the blended approach would be an effective and novel way to tackle the caseloads of our clinicians.

In closing, thank you undertaking this inquiry, and review of the current state of the mental health system in NSW. We have been neglected for some 15 + years, I can certainly attest to a decline across the last 8 years of my employment in NSW health. COVID-19 in some circumstances was an effective way to demonstrate just hour fragile and shallow the depth and breadth of our health system is. Mental health care during the pandemic as greatly impacted, however, it really only exacerbated what was already a serious problem prior.

Resident of NSW.

The 18th of July, 2023.

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