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ermha
VOICE AND CHOICE TO THRIVE

ermha formal submission to the Royal Commission into Victoria's mental health system

[redacted]

Contents

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Acknowledgements

ermha acknowledges the contribution of staff from the organisation's intensive services and complex client's teams, our Senior practice leaders as well as Executive Management in the preparation of this submission.

ermha also acknowledges the importance of maintaining privacy and client confidentiality. To that end, the organisation seeks the opportunity to be consulted prior to the reproduction or publication of any content arising from case studies featured in this submission.

About ermha

At ermha we believe in the potential of everyone. Our vision is for progressive reform, working with and advocating for people living with severe mental illness, mental disorders and psychiatric disabilities to be able to reach their personal potential. Our mission sees the ermha team work side by side with our clients, providing them with the compassion, care, advocacy and support they need to live the lives they want within a supportive community.

ermha has developed significant practice expertise in providing support to people with exceptionally complex and challenging behaviours for almost 40 years in Victoria and more recently in the Northern Territory. Our expertise includes the provision of numerous community and residential based services including programs where ermha is often considered the provider of last resort.

ermha and community based mental health services

For almost 40 years ermha has delivered a wide range of community based mental health services across Victoria. They include Prevention and Recovery Care PARC residential services, individual case management, assertive community outreach services, day and group programs. These have been funded by both State and Federal Governments. We continue to work with people experiencing mental illness, psychosocial disability, mental disorders and people with dual disabilities and those not eligible for the NDIS scheme.

ermha and the NDIS

ermha began the provision of NDIS programs at the Barwon Trial site in Victoria. Today ermha delivers NDIS programs and services across Victoria and now in Darwin.
ermha's programs include Specialist Behavioural support, Specialist support co-ordination and a range of core supports including supported independent living for numerous very complex clients with 24/7 packages of support as well as clients requiring intensive support in the community. We have supported hundreds of mental health consumers to transition into the NDIS. Some into services at ermha, others to a range of community-based providers.

ermha's submission focus

ermha is focusing this submission specifically about complex clients, people living with mental illnesses and mental disorders with a range of co-occurring complex needs. From our experience, they are some of the most marginalised people in the mental health service system today.

Specialising in supports for people with complex needs

ermha currently works with a large volume of clients with mental illnesses who present with complex needs. In many cases we have become the provider of last resort. People living with complex mental disorders co-occurring cognitive disabilities and challenging behaviours often have extended histories of self-harm, property damage and violence, placing at risk; staff, family members and the wider community. These clients with multiple, complex and challenging needs ('Complex Care needs clients'), are at significant disadvantage due to a combination of the nature and severity of their mental illnesses, disability status, persistent criminal offending behaviour, traumatic backgrounds and social isolation and require multi-agency support. Many of our clients will transition from lengthy stays in hospital wards and prison, as well as having ongoing involvement in the criminal justice and mental health services systems into our support in the community.

Recommendations

ermha specifically makes **two recommendations** to the Royal commission to address the challenges faced by clients with complex needs.

1. **Recommendation one: A new accommodation model to support people with complex needs to live safely in the community**

2. **Recommendation Two: The State urgently commissions a review into the division of financial responsibilities between DHHS and NDIA and commit to fully fund services for very complex clients in the NDIS.**

Recommendation one: a new accommodation model to support people with complex needs to live safely in the community

ermha has identified the need for a new accommodation model aimed at achieving better client outcomes and relieving pressure on the public system: ermha recommends the commission explores a "Therapeutic Village" that delivers better care and integrated services, specifically catering to the needs of complex Care clients. This first-of-a-kind village model will enable independent living within a communal setting, that supports the delivery of the full range of services required for each client. Key benefits will include:

- Improved quality of life - Clients should be accommodated in a safe and therapeutic environment oriented toward rehabilitation and community reintegration. The ability of clients to live in their own homes, safely and with appropriate support has been demonstrated to improve the quality of life of clients and minimize many of their harmful behaviours.

- Compliance with human rights laws - It is highly likely that in some of the current situations clients find themselves in result in a breach of their civil and human rights, which inadvertently are a direct result of alternative solutions to housing these clients not being viable or available.

Appropriate housing choices for Victorians living with Complex Care needs are very limited. When housing is provided that is not fit for purpose, there is often significant property damage and an increased safety risk to the individual and community. In many instances, delayed or inappropriate provision of support leads to long-term hospitalisations or incarcerations, which present severe infringements on an individual's human rights and significantly compromises their ability to achieve life goals. These prolonged admissions and detentions are often not clinically or legally justified but are a result of clients having "nowhere else to go". Once trapped in these circumstances' clients with complex and challenging support needs can enter a vicious criminal justice / hospital admission cycle, putting significant pressure on emergency services, prisons and hospitals.

According to the Office of the Public Advocate's Report (2018)1 there are a range of factors that characterise clients with Complex Care needs. They usually:

- have multiple and/or severe disabilities requiring various forms of support, often compounded by experiences of trauma
- experience issues with interpersonal engagement, such that they have limited family support and/or are unable to live with others
- engage in challenging behaviours that can put themselves or others at risk of harm
- are or have been engaged in multiple government service systems
- have exhausted (or are at risk of exhausting) service providers and workers
- have a history (or are at risk) of unstable accommodation, homelessness and/or periods in detention in the criminal justice and/or mental health systems and, as a consequence of the above fit for purpose, stable housing plays a critical role in the prevention of exacerbating existing conditions.

ermha has developed with Ernst and Young a detailed business case and literature review that supports the design, development and investment in this model. *This can be made available to the commission to review.* The business case estimates that a Therapeutic Village model housing 4 people will lead to avoided cost savings of approximately $929,000 p.a. across Government ($363,000 State Government and $565,000 Federal Government).

It is expected that a Therapeutic Village model will reduce the need for emergency services – police, paramedics, fire brigade. Avoiding or minimising unnecessary contact with these emergency services helps free up capacity within the system for those in greater need. While not every client will have contact with every authority, the associated costs can begin to accumulate significantly.

[1] NDIS (2018), 'Improving the NDIS participant and provider experience' available at https://www.ndis gov.au/media/1068/download (accessed 15 April 2019).

The Therapeutic Village model also aims to reduce the demand for hospital beds, justice facilities and the associated support costs. In many instances, inappropriate housing and care levels exacerbate negative client circumstances and may lead to the incarceration or long-term hospitalisation of clients

Numerous other benefits have been identified for both the Department of Health and Human Services ('DHHS') and Department of Health ('DOH') from supporting ermha's Therapeutic Village Pilot:

These include:

- reduced number of interventions and assessments from DHHS staff
- savings from programs such as MACNI
- savings on maintenance and repair costs associated with damaged housing from clients
- reduced demand for social housing
- reduced community concerns from anti-social behaviours
- positive messaging around a pioneering new process in support of Complex Care clients.

Case studies

To illustrate key themes ermha highlights challenges though the use of case studies. Pseudonyms have been used throughout this report to protect the identity of individuals and maintain client confidentiality in accordance with the NDIS Code of Conduct for Service Providers and statutory privacy obligations.

"Sally"

Diagnosis and presenting behaviour	**Sally** is a woman in her late 30s with a current diagnosis of 'pervasive developmental disorder' and 'borderline intellectual function'. Pervasive Developmental Disorder Not Otherwise Specified was a disorder listed in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM4) It was one of a family of developmental disorders that included Autistic Disorder and Asperger's Disorder. Numerous previous diagnosis includes psychotic disorders and schizophrenia. Behaviours of concern include mood associated with extreme distress that leads to prolonged periods of screaming and property damage occasionally threats of violence towards staff as well as concerns at her vulnerability in the community.
Past Service system experience and interaction	From her teens into her 30s, Sally received services through the mental health system. This included extended periods living in her local area mental health service's acute care, secure extended care and community care units. Sally's new diagnosis of pervasive developmental disorder and borderline intellectual function meant she was no longer eligible for these services. Her local area mental health service continued to accommodate her for some time but discharged her in her mid 30's.

	Sally had been incarcerated in Victoria's Dame Phyllis Frost Centre (Prison) since 2016 where she resided in the mental health Marmak Unit. She had been charged with breaching an intervention order taken out by her family and resisting police. County Court juries found her unfit to stand trial and not guilty because of mental impairment under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic). Under Victorian law, such people must not be detained in prison unless "*there is no practicable alternative in the circumstances*": see section 12(4). Regarding accommodation options for Sally, none were available for her to be released as it was considered she did not meet the criteria for admission. Mental health services advised Sally did not met the criteria under the *Mental Health Act 2014* (Vic). Disability Services advised Sally did not meet the intellectual disability criteria under the *Disability Services Act 2006* (Vic). As things transpired, Sally remained in prison for 18 months. As Victoria had no secure therapeutic facilities for women with Sally's disability, authorities were concerned about releasing her into the community because she had no housing or services. Due to Sally's' presentation and the unsuitability of prison, she was held in solitary confinement for up to 23 hours a day, would scream with distress and lost almost half her body weight while imprisoned in the Dame Phyllis Frost Centre. Victorian Ombudsman Deborah Glass described the 18-month imprisonment as "*the saddest case I have investigated in my time as Ombudsman*". The full report can be accessed at the following URL: https://www.ombudsman.vic.gov.au/getattachment/Publications/Parliamentary-Reports/Investigation-into-the-imprisonment-of-a-woman-fou/Web-PDF-investigation-into-the-imprisonment-of-a-woman-found-unfit-to-stand-trial.PDF.aspx
Service system failures	The ermha team commenced an NDIS package of support to help Sally live within the community and transitioned her from custody into a DHHS office of housing property. The service model provided by ermha to Sally was primarily a residential model with a 24/ 7 roster and 2:1 staffing. Within days of release from custody there were complaints from neighbours about the impact Sally was having on: their families; sleep; and ability to be in their front gardens or on the street. Neighbours made complaints to ermha, DHHS and the Local Members of Parliament, including sending videos of her behaviour. Sally also damaged neighbours' property and threw large pieces of her furniture on to the road. Within months neighbours successfully took out an intervention order and Sally had to be moved. Over the following months Sally resided in some 12 different accommodation placements. These included DHHS properties, private rental properties, short stays at hospital and respite care as well as numerous crisis placements in hotels and apartments. Sally's behaviours, whether in Metro or rural settings were considered unacceptable to the community in which she resided.

	Sally's admissions to Hospital included admissions to sedate and medicate Sally and 2 longer "social admissions" when there were no accommodation options available. During this time Sally's behaviour in the hospital meant she had to be sedated and / or physically restrained to ensure the safety of staff, other patients and their families, and to keep her from damaging property and equipment. ermha staff were required to support the Hospital with 2 staff 24/7 to help manage her behaviours and distress. As NDIS funding did not cover property damage, crisis accommodation and the various accommodation options including rent and make good, DHHS agreed to "top up" the package to enable each presenting crisis to be resolved. These interventions kept Sally in the community, avoiding a return to the prison circumstances that had led to the ombudsman's report. Following support from the office of the Chief Psychiatrist an urgent review was conducted in late 2018. It was agreed with the office of the Chief Psychiatrist that an urgent referral be made to the hospital for assessment and longer-term stay. The Hospital advised no beds were available. The following day Sally was arrested and taken into custody. 10 charges were laid, including 3 charges of assault and 7 of criminal damage to a motor vehicle or unlawful tampering with a motor vehicle. Sally was remanded into custody and taken to the Dame Phyllis Frost Centre. An urgent review meeting led by ermha, DHHS, NDIS and the office of the Chief Psychiatrist sought urgent accommodation for Sally. The magistrate agreed to release Sally back into the community where she is currently living in a specialist unit of a Hospital, supported by ermha staff for 12 hours a day. This placement has been agreed for up to 12 months. There is still no residential program available to Sally.

"Bridget"

Diagnosis and presenting behaviours	**Bridget** is a young woman with and intellectual disability with traits of autism. She is between 18-23 years of age. She receives support from a Dual Disability Service recognising that she does have a mental health condition. There has been some discussion of her displaying traits of schizophrenia, but no formal diagnosis has been made yet. Previous OT reports describe her as having high anxiety and often talking about self-harm ("*I want to die" and "I want to get run over*"). Bridget presents with significant behaviours of concern, these include violence and physical assaults towards her parent and sibling, whilst living at home, significant property damage / destruction – her parent stated that "*at one point, their home had almost no walls from eye level down*".

Past Service system experiences and interactions	Bridget lived with her parent and sibling in the family home. When she was a young adult, after an escalation in her behaviour, and significant violence she was removed from the family home by the police and was admitted to a local Hospital. From there she was discharged to a respite facility, this placement broke down within days due to self-harm and assaultive behaviour and she was admitted to a major Hospital where she remained for just under a year. During this time Bridget's challenging behaviours escalated and she would often attack staff posing a risk to the workforce and other patients on the general ward. The only way the hospital was able to manage Bridget's escalated behaviour included calling a "Code Grey" which meant she was physically restrained by hospital staff and then restrained to her bed frequently for the time she remained on the hospital ward. Due to her challenging behaviours Bridget was only allowed outside a few times during her inpatient stay, this was stopped by the hospital when she assaulted a member of the public when she was returning to the ward.
Service system failures	At the time of removal from her family home in her late teens, there was no destination in the community available to Bridget. The hospital accepted her as a social admission as she did not meet the criteria to remain in acute psychiatric care. Bridget remained living in the hospital on the general ward for 10 months. For much of this time she was restrained to her bed. Everyone involved in Bridget's case agreed this situation was unacceptable, however there was no alternative accommodation or service provision available. During her hospital stay ermha was approached to develop an NDIS plan and to provide support in the community. Initially ermha began in reaching into the hospital to provide some respite for hospital staff and to begin to build a relationship with Bridget. ermha assessed Bridget's needs and developed an NDIS plan. As the NDIA does not fund housing, and no SDA accommodation option was available DHHS sourced an office of housing property and worked closely with ermha to modify the building to meet Bridgit's needs. Significant challenges emerged during discussions with the NDIS with funding shortfalls identified in the areas of Specialist Support Coordination, Specialist Behaviour Intervention Support, Transport and Therapeutic funding. A compromise agreement was reached for 3 months of support given the situation in hospital had become untenable. ermha made the decision based on the complexity of Bridget and the situation that she was in to self-fund some of her supports to enable a transition into the community. Bridget is now living in her own home (office of housing). Her NDIS package is under review. If this situation does not change it will be impossible for ermha to continue to provide specialist support to her in the community.

"Mandy"

Mandy was referred to ermha in May 2018 by DHHS and at the time she was in custody at a Victorian Women's Prison.

Diagnosis and presenting behaviours	Mandy is a woman in her late 20s who is diagnosed with: • Moderate Intellectual Disability, • Major Depressive Disorder with psychotic features and • Borderline Personality Disorder (Cluster B traits). Mandy's behaviours of concern also include property damage, physical assault (staff) and attempting to exit moving vehicles.
Past Service system experiences and interactions	Mandy had more than 10 psychiatric admissions up to 2014 resulting from deliberate self-harm, expression of suicidal thoughts, expressing plans and intent to harm herself, her mother and people she had tried to befriend. Mandy was referred to ermha in 2018 and at the time she was in custody at the prison where she faced [redacted] charges including multiple charges of stalking, making threats to kill and kidnap and multiple breaches of IVO's dating back to 2015.
Service system failures	Mandy was found unfit to stand trial however she remained in custody for a considerable period of time as there was no suitable accommodation or funded support available in the community. A case conference report from 2018 stated that the unit in the jail was not suited to meet her needs "*as she required 2:1 support with all aspects of daily living"*. Seclusion had been used to manage her behaviour, resulting in Mandy remaining locked down in her cell for approximately 23 hours a day for the duration of her prison stay.

"Nigel"

Nigel is a young man in his mid-20s. He was originally referred to ermha as a Victorian DHHS Disability client with an individual support package. Because of the complexity of his needs he was also identified as a Multiple and Complex Needs Initiative (MACNI) client. Nigel transitioned into the NDIS in 2019.

Diagnosis and presenting behaviours	Nigel has been diagnosed with • several mental disorders (namely autism) • Oppositional defiant disorder, • Antisocial personality disorder, and • intellectual disability. Nigel was assessed to be substance dependent, to have engaged in a range of violent and other behaviours that placed both himself and others at risk and deemed to require intensive supervision. His substance use and offending behaviours have seen him spend periods of time in custody. Nigel transitioned to the NDIS in 2018. At the time of his transition he was being held in custody.
Past Service system experiences and interactions	Due to the nature of his disability and his presenting behaviours it became impossible for Nigel to remain in the family home. Nigel has been involved with DHHS services in Victoria from a young age including living in out of home care. He has also been transient, homeless and spent periods of time in and out of prison.
Lack of suitable housing leading to scheme failure	Housing has been one of the most significant issues for Nigel and in trying to accommodate his needs there has been a significant strain placed on the service sector. Nigel has a history of unstable housing in several settings, including properties supplied under an 'out of home care' arrangement, properties supplied by community agencies, properties on his own, properties with others and supported disability accommodation. Some of these arrangements have involved the presence of multiple staff, including in a 2:1 24/7 model. At the time of writing this submission, Nigel is incarcerated as his most recent accommodation option broke down and he subsequently breached his bail conditions. His period of incarceration is currently extended as there is no suitable residential address for Nigel to be released to. Nigel's NDIS package totals almost $300,000. His family are extremely frustrated that support cannot be provided to Nigel if he has nowhere to go. He is unable to return home and his family are unable to fund private rental for him. In receipt of Centrelink benefits he has limited income, very little prospect of immediate employment so securing appropriate and affordable accommodation is problematic. Whilst he qualifies for an NDIS package of support this is not currently being provided

Recommendation Two: The State urgently commissions a review into the division of financial responsibilities between DHHS and NDIA and commit to fully fund services for very complex clients in the NDIS.

ermha currently provides NDIS services for people with significant mental disorders and mental illnesses. We provide specialist behaviour support, specialist support co-ordination and core support working directly with people though the provision of a range of 24/7 exceptionally complex packages. This is currently considered to be a "thin market" ermha estimates that around 600 people across the country would fall into this category of need. In Victoria though would be anywhere up to 100 very complex and challenging cases.

Servicing this thin segment of the market has proven challenging for ermha. Whilst we can develop packages of support and bring our practice expertise to deliver support for some of the most complex and challenging people in the community, the division of financial responsibilities between DHHS and NDIA must be clarified to ensure quality and safeguarding remain at the centre of service delivery for very complex clients.

Our experience is that the NDIA operates under extreme pressure in terms of time and resources. This pragmatic environment, and the general requirements on the NDIA to use public resources efficiently, incentivises the adoption of standard business rules. Although such practices are understandable and may yield good results in other parts of the NDIS, in our view, there is a shortfall of required investment in adequate levels of specialist behavioural support and support co-ordination for very complex clients. In short, the 'one size fits all' approach does not work for very complex clients.

The interface between the clinical mental health system, the Justice system and the NDIS must be clarified and communicated with precision (both Federal and State Jurisdictions). Debates about "who pays for what" need not arise - a clear division of financial responsibilities **in advance** will give service providers, families and other stakeholders certainty and confidence leading to better outcomes. In determining the optimal division of financial responsibilities, the best interests of the participant need to be central in all discussions. From our experience, the risks to staff, community and the clients dramatically increase without adequate funding and support.

Whilst DHHS has helped fund gaps during the transition phase (as highlighted in the case studies presented in this paper), it is presently unclear how long State Government Departments will step in with "safety net" funding. Without State Government intervention, ermha would not be able to provide a safe and viable service for numerous complex packages. This piecemeal approach presents a significant risk for organisations delivering services where risk to client, community and staff is high. Ultimately, it is also economically detrimental to the State, since the complex clients who 'slip through the cracks' often end up utilising resources in the public hospital and/or prison system.

An urgent review is required for those complex clients impacted by the state / NDIS transition and urgent investments in their care be made.

- As such ermha recommends DHHS urgently review the most complex and challenging cases that have transitioned into the NDIS over the past 18 months.
- The review should consider State Government investment before transition and review the levels of funding support agreed by the agency as part of the clients NDIS plans examining funding and support shortfalls.
- The review should examine the additional costs associated with the provision of support through other means when NDIS provision is not available e.g. the additional cost to the State to house someone in hospital of prison for a lengthy stay.
- These findings should be published and should form the basis of ongoing considerations by the State as to how this group is adequately funded to live safely in the community.

Case studies

To illustrate key themes ermha highlights challenges though the use of case studies. Pseudonyms have been used throughout this report to protect the identity of individuals and maintain client confidentiality in accordance with the NDIS Code of Conduct for Service Providers and statutory privacy obligations.

"Liam"

ermha received the initial referral to provide services for Liam from DHHS. ermha was considered the provider of last resort in this case. Liam needed to transition from the youth system into the NDIS as an adult on his 18th Birthday.

Diagnosis and presenting behaviours	Liam is a young adult aged between 18-23. Liam's diagnoses include: • Schizophrenia, • Post-Traumatic Stress Disorder, • Borderline Personality Disorder traits, • Gender Dysphoria, • eating disorder and • reactive attachment disorder. Liam struggles with major issues of self-injury, inability to self-soothe and all aspects of his cognitive, emotional, and behavioural functioning is fractured. Liam hears derogatory voices commanding him to commit suicide and to harm others. Self-harm behaviours including head-banging, swallowing objects, breaking objects / wall fixtures to cut self with and self-strangulation. He has overdosed on prescription medication on numerous occasions and is at extreme risk of death by misadventure. In addition, Liam has an extensive history of contact with the justice system. His current charges include attempted murder of a staff member.
Past Service system experiences and interactions	Prior to engaging in the NDIS Liam's services were provided through Department of Health and Human Services Victoria (DHHS). These included numerous out of home care placements as a child, along with ongoing engagements with the child protection and youth justice systems as well as numerous hospital presentations and lengthy admissions.

	DHHS had discussed the case with other service providers, but due to the level of risk to the client, staff and the community other agencies had declined the opportunity to develop a package of service.
Service system failures	A key challenge for providers delivering services at the exceptionally complex end of the NDIS scheme is that the time dedicated for assessment and development of an individually tailored package is very rarely funded. Over a 9-week period senior staff at ermha spent considerable time working with DHHS, NDIS, Clinical mental health services, Juvenile Justice, Housing, Child Protection and the exiting provider and Liam himself to understand the risk and need to be able to establish the right plan and model of service for support for an NDIS package. ermha assessed Liam as having complex, multiple and high needs, requiring the expertise of a specialist practitioner to develop a comprehensive Behaviour Support Plan and to guide implement, monitor and review this plan to provide direction and support to the support worker staff team equipping them to deliver a high quality and safe service. As Liam's diagnoses are purely mental health there has been significant challenges in developing his package of support with NDIS agency staff. There is an expectation from the NDIS that the clinical mental health system should provide specialist behaviour support and intervention. Clinical mental health services believe funding for this should be provided by the NDIS. The NDIS scheme would fund double support staff at a SCHADS level 3 providing 24/7 direct services (core supports) along with Standard and Specialist Support Co-ordination. However, Liam's complexity requires a higher level of experience and expertise from his support team, beyond that of SCHADS level 3. The team will require specific clinical skills, supervision, reflective practice and debriefing, particularly Specialist Behaviour Support. it was difficult to reach an agreement on the hours required for specialist behaviour support. The inclusion of specialist behaviour support was considered critical by ermha. A significant funding gap emerged which meant ermha could not deliver a safe service for Liam. ermha worked closely with DHHS to seek additional funding to fill the gap in this case. DHHS agreed to provide additional funds to support the provision of specialist behaviour support services for the 12 months the NDIS plan was approved.

"Danny"

Danny was referred to ermha in 2018. Due to the limited availability of suitable housing, Danny had been placed in a DHHS house in a rural township 150kms or around 2 hours' drive outside of Melbourne.

Diagnosis and presenting behaviours	Danny is a man in his late 30s with moderate Intellectual Disability, Autism Spectrum Disorder and Foetal Alcohol Syndrome Disorder. Danny's receptive, expressive and pragmatic language skills are significantly impaired. Danny has a lifelong history of aggressive behaviour including physical aggression (hair pulling, hitting, strangling, punching, kicking, grabbing), verbal aggression (swearing, yelling, threats to harm himself or others), property damage (throwing objects, kicking objects, breaking windows). These behaviours may be directed at family members, support staff or members of the community. Danny's behaviour can be unpredictable and impulsive.
Past Service system experiences and interactions	Danny is subject to a supervised treatment order (STO) under the *Disability Act 2006*. The application for the STO was made prior to ermha engaging with Danny due to an increase in the risk of physical harm towards others that had occurred since at least 2015. The need for the STO was emphasised after several separate instances of assaultive behaviour for which Danny is currently facing unlawful assault charges. The STO requires Danny to be supervised by two staff 24 hours per day. Assessment suggests that Danny continues to present a moderate to high risk of engaging in violent behaviours. Adding to his complexity is that there is little warning for his behaviours, so these have been difficult to predict and proactively respond to. In 2016 Danny was hospitalised for excessive alcohol intoxication which resulted in him remaining in a comatose state for more than a week. He was transferred to the high dependency psychiatric unit of the hospital for extensive assessment. This admission resulted in a further diagnosis of Psychosis. Danny was referred to ermha in 2018. Due to the limited availability of suitable housing, Danny had been placed in a DHHS house in a rural township 150kms or around 2 hours outside of Melbourne. DHHS was using a temporary staffing agency to provide rostered support. Danny's package of support from DHHS was approximately $2m a year. This included 24/7 double staffing, support co-ordination and behavioural support. A significant component in the package included travel allowances to enable suitably qualified staff to be able to travel to the rural area to provide support for the temporary staffing agency and subsequently ermha have been unable to source and recruit any local staff able or willing to engage with Danny.

	Due to Danny's complexity ermha is required to attend monthly care team meetings with all the professionals engaged in Danny's care and report on compliance with his STO as well as providing written weekly updates. Because of the inherent risks in supporting Danny, ermha staff attend three-hour monthly group reflective practice facilitated by an external specialist clinician as well as taking part in weekly debriefings, incident management and follow up.
Rural and remote staffing challenges	Danny transitioned into the NDIS in early 2019. His package of support reduced by 50%. Some of this is a result of the work undertaken by ermha and a reduction in some of the risks presented by Danny. This is a positive outcome. However, in the package allocated to Danny the agency has not funded the travel required to be able to bring the specialist staff to rural Victoria. Funds required to pay staff for travel time to work with Danny cost in the region of $22,000 a month. This change has made the provision of services for Danny as untenable. The time for staff to attend reflective practice and Danny's care team meetings are also not included. If these matters are not resolved, ermha will have to cease operating our support for Danny. There is currently no provider able / willing to establish services in a local area to deliver support for Danny if ermha withdraws from his care.

ermha acknowledges Aboriginal and Torres Strait Islander people as the Traditional Owners and Custodians of this country, their connection to land, water and community. We also pay our respects to their cultures and customs, and to Elders both past and present. ermha is committed to contributing to the Closing the Gap initiatives by improving health outcomes for Aboriginal and Torres Strait Islander people.