COMMUNITY SUPPORT AND SERVICES COMMITTEE

Members present:
Ms CP McMillan MP—Chair
Mr SA Bennett MP
Mr R Molhoek MP
Ms JC Pugh MP
Mr RCJ Skelton MP

Staff present:
Ms L Pretty—Committee Secretary
Dr A Lilley—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE PROVISION AND REGULATION OF SUPPORTED ACCOMMODATION IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

Wednesday, 13 December 2023
Brisbane

WEDNESDAY, 13 DECEMBER 2023

The committee met at 9.03 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into the provision and regulation of supported accommodation in Queensland. My name is Corrine McMillan. I am the member for Mansfield and chair of the committee. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples whose lands, winds and waters we all now share. We acknowledge and convey our deepest wishes and concerns for our colleagues, friends and families in Far North Queensland. We recognise that many of the community who will be affected by Tropical Cyclone Jasper are our vulnerable First Nation peoples.

I acknowledge with me here today: Mr Stephen Bennett MP, the member for Burnett and deputy chair of the committee, who I am sure sends his best wishes to the north as well; Rob Skelton MP, the member for Nicklin; Ms Jess Pugh, the member for Mount Ommaney, who is standing in for Ms Cynthia Lui MP, the member for Cook, who understandably is in her electorate; and Mr Rob Molhoek, the member for Southport, who is standing in for Dr Mark Robinson MP, the member for Oodgeroo. Mr Michael Berkman MP, the member for Maiwar, is unable to attend today's hearing. The committee was to travel to Townsville and Cairns in the coming days to hear from stakeholders in North Queensland. Unfortunately, due to Tropical Cyclone Jasper the public hearings and site visits have been postponed. I wish everyone safety and well wishes as the cyclone passes.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in today's proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee or at my discretion as chair. These proceedings are being recorded and broadcast live on the parliament's website—thank you to our parliamentary team. Media may be present and are subject to the committee's media rules and my direction at all times. You may be filmed or photographed during these proceedings and images may also appear on the parliament's website or social media pages. Please turn your mobile phones off or to silent mode.

CHESTERMAN, Dr John, Public Advocate, Office of the Public Advocate

MARTELL, Mrs Tracey, Manager, Office of the Public Advocate

CHAIR: I now welcome representatives who are no strangers to our committee from the Office of the Public Advocate. Good morning to you both. Dr Chesterman, would you like to make an opening statement, after which I am sure our committee will have many important questions.

Dr Chesterman: Thank you for the opportunity to be here. I also acknowledge that we are on the traditional lands of the Turrbal and Yagara people and I pay my respects to elders past, present and emerging.

As members of the committee know, as Public Advocate for Queensland I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability. There are several conditions that may affect a person's decision-making ability, including: intellectual disability, acquired brain injury, mental illness, and neurological disorders such as dementia or alcohol and drug misuse. As members know, my office completed the report on supported accommodation that led to this inquiry. I do note I was very appreciative that the government supported my report's sole recommendation—that is, to have this inquiry. I am likewise very pleased that this is the committee that is conducting the inquiry. My report, as you know, also contained 29 questions which have been referenced in this committee's terms of reference. It is great too that the committee has embraced my suggestion to engage with residents and former residents of supported accommodation settings and that it is enlisting two excellent non-government organisations to assist with this.

I do note early on that, in using the term 'supported accommodation' as discussed in my report, I refer not simply to level 3 residential services as defined by the Residential Services (Accreditation) Act but also other shared living arrangements including level 1 and 2 services and other accommodation settings made possible through the receipt of NDIS support. This is important because the advent of the NDIS has meant that some participants who might otherwise be recipients of level 3 residential services can now be supported with NDIS funding in the delivery of relevant personal care services. That means that the person—indeed, many or even most people—living on the site of a registered level 3 residential service or next door may not technically be actually receiving level 3 services because, for instance, their medication management is managed with NDIS funded support. At the same time, the same accommodation provider or a closely related entity may be running a SIL, supported independent living, house right next door. This obviously creates extraordinary regulatory complexity, but it means that focusing regulatory attention solely on the provision of level 3 services will not capture the full picture.

Since finalising my report we have had the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, which released its final report. Members would know that among the royal commission's 222 recommendations was recommendation 7.38, which sought a range of reforms to establish minimum support standards and monitoring of the equivalent of supported residential services, which is a Victorian term. In Queensland that is level 3 residential services. I will perhaps mention that later on during discussion. I see today not as an opportunity to go over the reasons for my report's call for this inquiry, although of course I welcome any member's questions or comments in that regard. In these preliminary comments I thought I would flag the four areas that I think the committee might consider delving into when it comes to finding ways forward for the supported accommodation sector to meet the needs of the resident population that contains many people whom I would identify as being at some degree of risk.

The term 'at risk' is one I use that has been defined by the Australian Law Reform Commission previously. It refers to people with care and support needs who are unable, because of those care and support needs, to protect themselves from abuse or neglect. The four reform areas to which I will turn are areas on which I will be continuing to develop reform ideas in a bid to assist the committee in its work. I will be making a written submission in due course, and I hope it might even be possible to return to speak to the committee after that should the committee wish for me to come back.

An initial or perhaps even foundational question for us in the process of this inquiry is to ask whether it is acceptable, from a resident's point of view, to have people in 2023 living in state regulated accommodation settings in which in some cases bedrooms and/or bathrooms are shared and in some cases very large common kitchen and dining areas are shared with others. These do give some settings a very institutional feel. Another foundational question concerns the future of level 3 residential services as a regulatory category with the advent of the NDIS. Some supported accommodation providers are registered for the provision of level 3 services but have few residents actually receiving level 3 services because that level of support now comes via NDIS funded support.

Another preliminary question is whether level 3 residential services in particular ought to be seen as transitional or long-term housing options. Here I would always be guided by what the residents themselves want. I know that for some people their residence is their home and they do not want to leave. Others, if they were presented with viable alternatives and some assistance, might choose to live elsewhere. I will return to this point briefly at the end of my preliminary comments.

I will list four areas I would respectfully note are areas where there is need for reform. The first is the topic of a sector census. We need to know more about the characteristics and service needs of residents. We know that residents in this sector have very high rates of disability and mental ill health and have very significant support needs. Anecdotally, occasionally we hear that a significant and possibly growing proportion of residents have mental health needs that are not being adequately met, and that is different according to the setting you go to. There have been some attempts to do a census supported by the Department of Child Safety, Seniors and Disability Services, and it would be good to see the outcomes of such initiatives and potentially expand them in future.

The second point I would flag is concerns around what I call person-centred regulation. I think it is important for us to think about how regulation in this field can become less facility based and more person centred. That is going to be ever more important as we see new accommodation settings continuing to be developed, making facility-based regulation ever more problematic. I would define person-centred regulation as regulation of the adequacy of the services received by an individual. The focus is on whether the person is receiving adequate services to meet their support needs, which is different from facility-based regulation, which focuses on the regulation of services provided by a facility.

Committee members would have seen the regulatory diagram at page 10 of my report, which indicates a confusing amalgam of regulatory bodies and requirements in this sector. The concern I have is that our existing regulatory approach is probably good for important areas like food and medication management, but when it comes to equally important topics like the service and social support needs of residents, social connectivity and safeguarding, the approach is limited and insufficiently person centred. I know that some providers of supported accommodation—indeed, some of whom are in this room as I speak—are very person centred and care very much about the individuality and wellbeing of their residents, whom they know very well. I also know that some proprietors do not meet that threshold. The point is that, as a regulatory approach, our focus at present is very much on the institution rather than the person. The advent of the NDIS indeed makes the transition to person-centred regulation paramount.

Those comments are not a criticism of the historic regulation of the sector, just mindful that we need a new approach. I will give an example. The Department of Housing asks in its auditing process some questions about the participation of residents in the NDIS. However, the very helpful written briefing provided from the department to this inquiry makes clear in discussing a number of questions from our report—questions 14, 19, 20, 21 and 27—that the department does not hold useable data on which residents are NDIS participants nor does it have a direct role in relation to intake and assessment processes, the assessment of residents' support needs, the navigation of the service system or the regulation of restrictive practices. To be effective here, the regulation of the sector needs a person-centred, human services approach. I can say more about that later on should there be time and inclination from the committee.

Very briefly, there are two other points I want to flag. One is case management. I think it is important for us to think about some of the very significant unmet support needs of people in supported accommodation situations. While criteria for access to any new case management offerings in Queensland would need to be determined and have a carefully targeted approach, I think doing this would, in the end, likely prove cost neutral. We also want to factor in the cost of a variety of systems that are eventually in play if things fail. I would suggest the possible threshold criteria for access to case management would be that the person is living in a residential service and currently has significant unmet support needs. Case management might include assistance to find appropriate support services or even assistance to find alternative accommodation where the person indicates an interest in moving elsewhere and if, for instance, their health and support needs would be better met elsewhere. I parenthesise that by saying this is one reason case management would need to be provided by an entity other than the accommodation provider.

Very briefly, my fourth comment—and I can look at this more in response to questions should the committee be willing to address this issue—concerns the topic of adult safeguarding. I have previously released a report on this topic. Our current regulatory approach in the supported accommodation sector requires providers to have policies and procedures on preventing abuse and neglect. That really provides little in the way of effective safeguarding. We know that emergency services are often called to supported accommodation settings. In my adult safeguarding report, which is still under consideration by the Queensland government, I called for the appointment of an adult safeguarding commissioner who would be able to address situations concerning at-risk adults, many of whom do reside in supported accommodation settings. There are a number of other things I could of course say, but I am mindful of the time and I will pause now and welcome committee observations and questions. Thank you for having me here.

CHAIR: Thank you, Dr Chesterman. On behalf of the government I say we certainly value the work that you put into the inquiry and your report has guided us immensely. We thank you and Ms Martell for your service to Queenslanders and particularly to our most vulnerable. Thank you for your great work. We are very proud as a committee to take your work and investigate further.

Mr BENNETT: Thanks for asking 29 questions. You have certainly given us a challenge to work through what is a very complex area. Having not been exposed to it, our first reactions are what a complex and difficult environment a lot of this is. In question 2 you talk about different models. First of all, you talk about bricks and mortar, and that is another question. Are you able to elaborate on what you would see because it seems to be a really complex area? Who knows how hard the sector was struggling before the NDIS. In relation to question 2 can you give us any insights on what you would think new models should look like? I am looking for answers, not questions.

Dr Chesterman: Yes, I have said to my team—and I want to thank the chair for her comments and I want to praise my team for their work in bringing this report together—that I think we are obliged to come up with some answers to questions, too. The reason the report's sole recommendation called for this inquiry is because I had more questions than answers and there are others with expertise in

this field. In answer to that question, I think there is a range of social housing possibilities. I think there is a case to be made for greater government investment in the sector in a range of ways. I know that there are a number of current providers of supported accommodation who would welcome greater government investment in the sector in terms of even purchasing bricks and mortar and the engagement of support services to provide services to at-risk people.

We see a rising number of innovative models of support out there. I can think of one recently in Quigley Street, Cairns, where there is new supported accommodation for six households. Those households were either experiencing homelessness or at risk of it. I think we can learn a lot from the homelessness sector. Historically the supported accommodation sector has been seen as separate to the homelessness sector. There are arguments that the two are much more closely aligned than we might first have imagined and that indeed an unpalatable option for many people in supported accommodation settings were they not to be there would be homelessness. I think the merger of those two sectors would be very important.

I am just flagging the points I made earlier about person-centred regulation. I think there are things we can do to bring other expertise into the regulation around people who are living in supported accommodation settings. We have here in Queensland something called the Human Services Quality Framework—and the most recent version is version 8 from a year ago—which contains relevant standards that could be drawn upon to provide a more human services, person-centred regulatory approach to this area. One standard I will pull out is under the heading 'Responding to individual need'. It is articulated in this way: 'The assessed needs of the individual are being appropriately addressed and responded to ...'

Another thing we could do is have an assessment of people in level 3 residential services to begin with and perhaps extend to other residential services like level 2. There could be an assessment of their current service and support needs which could be auspiced by the Department of Child Safety and Seniors and Disabilities Services. There could be a panel so that providers could be funded through an administrative fee to organise assessments of residents. That is another option. I think the broad field of social housing is one that is capacious of lots of innovations that could house many people currently in the supported accommodation sector.

Mr BENNETT: In your executive summary you talk about housing and legislation versus social care and regulation. From your response it seems we are drifting towards social care being the focus as opposed to the housing standards.

Dr Chesterman: Indeed.

Mr BENNETT: Is that a fair statement?

Dr Chesterman: Yes, that is.

CHAIR: Dr Chesterman, I wonder if you would not mind emailing the committee a copy of that document you just referred to.

Dr Chesterman: Certainly.

CHAIR: That would be tremendous. The committee notes the framework through which you advocate—the social care framework rather than the housing framework. That has underpinned a lot of our work as a committee so far.

Mr SKELTON: Dr Chesterman, in your report about supported accommodation you posed 29 questions for the committee to consider. If you were to put together a list of the five most urgent priorities, what would they be?

Dr Chesterman: That is a good question. Addressing urgent care and support needs of particularly at-risk residents would be the first thing. That would be a census of current residents who are most at risk in terms of their service and support needs. That would be the first area. I would have to take the question on notice to try to prioritise. I think there are about 15 topics, but I want to say what will be the top five. I could take that away and come back very shortly with the top five priorities if the committee is willing to indulge me in that?

Mr SKELTON: I am happy with that.

CHAIR: Thank you.

Mr MOLHOEK: Thanks for the opportunity to be here today. Thanks for your work, Dr Chesterman. We have met on a few occasions and you are certainly a great advocate for Queenslanders. I appreciate your hard work and your passion for what you do. My question is probably a little bit left of field. I have seen cases where the desire to protect the public interest or the interest of individuals from exploitation has been so overwhelming that it almost works against the

greater need of actually putting a roof over someone's head. I would appreciate your comment around that. I suppose the question is: are we overregulating? The difficulty is that we do need to protect people but I feel we are spending so much in resources, time and legislation in protections that we are not necessarily meeting the need.

One particular example is I have a drug and alcohol rehab in my electorate. They provide supportive accommodation. It is an environment where people are rubbing shoulders and sharing rooms. They have been operating out of a very old motel for years and they looked to actually buy a backpackers hostel and substantially expand—almost treble their service. At the time the Department of Housing knocked them back because all the rooms were not privately ensuited. The argument would be that some of the benefit of being in that program is you actually do have to work out your relationships with other people. The question is: are we overregulating? Are we going too far with this?

Dr Chesterman: It is certainly a danger in this space and I think we have to not lose sight of the main issues at play, which are housing for the person and meeting support needs. They are the fundamentals. I think there can be a risk if we end up finding ways of doing lots of other things other than providing those two keys. I think in our regulatory attempts we have to be guided by what the person themselves want. We have to have a kind of minimum threshold where we are saying, 'If this is government regulated we are not going to go below that,' but we also have to have capacity for people to say, 'This is where I want to live.' That is why, for instance, I would not rush to say, 'We should be shutting down X, Y or Z.' We need to speak to residents to find out what they actually want.

Your comments about overregulation are interesting because in the field of adult safeguarding the key recommendation I have is around the appointment of a commissioner whose office would be solely involved in finding solutions to social care situations of concern rather than calling emergency services. Often emergency services' time is spent on social care situations which could be better addressed in other ways or we use the adult guardianship system, which is an extremely costly and heavily regulated field. We use that unnecessarily on many occasions as well. I think your comments about the concerns about overregulation are well made.

Mr MOLHOEK: How could we strike a greater balance from a legislative point of view? Some people thrive in communal environments. It deals with social isolation and a whole lot of other issues, but this obsession of everyone having to have their own place, their own bathroom and their rights to have eight-foot-high ceilings and minimum standards is not the real world. It is denying a lot of people opportunity.

CHAIR: Member for Southport, do you mind just stating your question?

Mr MOLHOEK: How do we create a legislative environment that can be more accommodating to a broader range of options?

Dr Chesterman: The comments actually resonate with me because I have been fortunate to conduct a number of visits to supported accommodation settings including some of the ones you will hear about later on. If you are interested, some of the proprietors are sitting behind me. There are occasions where I have met with residents and some residents are very happy where they are. I would be loath to be requiring them to move elsewhere simply because of a regulatory requirement. The answer to that is we have to be guided by what residents themselves want. That is easier said than done though, but we have to be careful. Some residents have had very limited experiences of alternative accommodation settings or, indeed, have been homeless or in jail or somewhere else and so they may at first blush say, 'I'm very happy here,' because the comparator is far worse. We have to be a little bit more robust than just saying, 'Do you want to live here?' Having said that, though, that needs to be our primary frame of reference, what the person themselves wants. We need to be mindful, too, there are minimums we would have to agree upon when we are talking about state regulated facilities. We would all agree there needs to be a minimum. In terms of what those minimums are, there perhaps might be a different views.

Ms PUGH: I am substituting for Cynthia Lui as obviously her community is very affected by the coming cyclone. I am grateful to have the opportunity to be part of the proceedings today and thank you for being here. My question goes to your opening statement around a safeguarding commissioner. Would you be able to expand on that role? Did I hear that correctly, sorry? You do speak very quickly. I was struggling to keep up and take a few notes. Did I mishear you?

Dr Chesterman: That was the main recommendation from a two-volume report on adult safeguarding in Queensland which addresses the question of who you contact in a situation where an adult is at risk of harm but there is no obvious medical emergency or obvious crime that has been committed. At the moment, we tend to rely on emergency services in those situations and/or the adult

guardianship system. This is an alternative to both of those which has wide support. A number of state law reform commissions have made a similar recommendation. New South Wales has made a comparable appointment. We recently had the disability royal commission recommendations which recommended that model, and we also had even more recently the NDIS review which recommended reforms down that pathway in the adult safeguarding field. It is an idea that is not particularly all that novel now, but it is one that is certainly relevant to this sector.

Mr BENNETT: Are you able to make a comment on your observations? We have only just started the inquiry and we have made a site visit. One of the staff I was sitting with, a wonderful young person, raised the qualifications and the complexity of residential assisted living. I believe it is only a certificate III and some first aid that they need. Someone is shaking their head. Maybe I can get clarity. We have only just tried to immerse ourselves in what all this looks like and I am wondering if we understand the complexities of what the staffing of a facility would look like.

Dr Chesterman: Some of the staff providing particular services are required to have first aid and CPR training, but you will be hearing later on from some of the providers who will be able to talk through the training that their staff members receive.

CHAIR: To follow on from that question, Dr Chesterman, do you see benefit in professionalising the sector by suggesting some qualifications? How do we better prepare? It is a very complex environment to work in. Can you provide further comment to the deputy chair's question?

Dr Chesterman: There is some debate in the sector and indeed very recently nationally with the NDIS review that has been conducted about the requirement for providers of NDIS funded services to be registered or not registered and the minimum threshold. It really does go to that question of: what is the service that is being provided; what is the risk; what is the benefit of requiring training; what training is available; and what are the intended and unintended consequences of having that requirement in terms of staffing and so on? If we look at the NDIS as a guide, I think the NDIS actually is a useful guide here for the requirements for training for particular providers of services. Obviously not so much if you are mowing someone's lawn, but, yes, if you are providing personal support, absolutely there is a requirement for some level of training.

CHAIR: Does that change or is there a new lens on that area of the sector, given your thoughts around the social care versus the housing model? Is there any impact there?

Dr Chesterman: Yes. The idea would be to bring in the expertise that exists in the social care field. As well as including the Department of Housing, I am thinking of the Department of Child Safety and Disability Services that has expertise in that more social care field, and learning from other advanced systems that are in place, including the NDIS, because, as I was saying, many residents of current level 3 registered services are actually receiving NDIS services.

CHAIR: During the committee's inquiry into social isolation and loneliness we certainly spent a lot of time looking at the professionalisation of the sector in relation to community centres. I think that whole social sector within our Queensland workforce certainly requires some underpinning background or education or standards?

Dr Chesterman: I think that is right. I am pleased you mention that inquiry. It actually echoes my response to the member for Southport because isolation is a significant risk factor for at-risk adults coming to harm in one way or another, and that is why we need to be mindful of enabling people to live in settings of their choosing where they can socialise as they wish. I am echoing your support for training in that sector, but there is a danger in moving from one model to another model which might, for instance, see people living on their own in a suburban house, spending time in their bedroom and not engaging with anyone because there is no-one around them who they would like to engage with. You have to be a bit careful of going down that trajectory.

CHAIR: Thank you. That certainly swings me towards the member for Southport who raised the issue in the first place.

Mr MOLHOEK: Again, I am keen as to how we could create a regulatory environment that would provide greater flexibility. In the particular example I gave earlier, they were up against regulation or law that prohibited that change, and yet the organisation had been operating from, and would continue to operate from, a much smaller base. How do we legislate? Do we need to give more power to, say, the Public Advocate and have less enshrined in the legislation?

Dr Chesterman: It is a good question. I would be calling for, in our regulation of the sector, as I say, a more human services approach, but also have a greater emphasis on on-site assessment; going out to the place and assessing, 'How is this going?' This is no criticism of how things have

happened in the past. A plethora of new accommodation settings are arising, particularly with the advent of the NDIS that has enabled this to happen. I suggest onsite visits where you are guided by some key principles, where residents play a very significant role to the extent of their ability in speaking with assessors about what their views are about where they are living. We do not want to go down the path of having regulation that is too book-bound, if you like, and, 'Do you have this policy or don't you have the policy?' rather, how it is operationalised. I would be wanting to emphasise onsite visits that have a human services approach.

Mr SKELTON: Are there any strong models you can think of that might inform Queensland's regulation of these services? Are any states or other countries doing a better job, or the NDIS?

Dr Chesterman: It is a great question. I would have to rush to say unfortunately not in Australia. The Disability Royal Commission report does have a brief section where they use the term 'supported residential services' which is the Victorian equivalent of level 3, and they found lots of problems with the Victorian system. I am very familiar with the Victorian system being from Victoria, several years ago. That is a bigger sector, but I would not be pointing to that as a better sector. There are some excellent providers in Victoria, and indeed here in Queensland there are some excellent providers.

My suggestion to the committee is to make its own assessment about who those excellent providers are and then find out why it is that they are able to operate at that level and how can we encourage/require others to operate at that level. There are models overseas of situations where government plays a significant role in the infrastructure—buys the house and tenders out the support services to a variety of players. I point to Common Ground here in Brisbane as an example of a really effective model. That will not be right for all residents in the supported accommodation sector, but it is one that I would point to as a really strong one.

Mr MOLHOEK: Have you looked at issues around planning reform and the impact of planning guidelines, so the Queensland Planning Provisions, and then the impost of those down the line on councils and local authorities in terms of how they town plan, what they can and cannot do, and what standards are to be met? To me, I think planning is one of the biggest social levers you can pull. Have you looked at planning and the impact that that is having on supply?

Dr Chesterman: I have not looked at that in any depth. Supported residential facilities, as they are called in South Australia, are governed at the local council level, and I know that there are some challenges with that. In terms of the member's question, no, I have not looked at planning laws and requirements and the extent to which they would be perhaps inhibitors of more interesting accommodation alternatives, but I do accept that they are very important here.

Mr MOLHOEK: I would be interested in your views on what is commonly known as family accommodation, I think, under local planning laws—granny flats, Fonzie flats, or some people put a portable home type thing in their backyard for family accommodation. Do you think we should be opening up provisions around that and making it more broadly available?

Dr Chesterman: Yes. Certainly in a situation where there is extreme pressure on housing, we would look at all kinds of possibilities for freeing up available land for the use of housing. This is why this inquiry is so important. We want to identify, from my perspective, the cohort of the population who are—I have been using the term—at risk, because of their care and support needs. We need to make sure that their needs and interests are catered for and monitored. As I keep saying in regards to the adult safeguarding sphere, we need to have eyes on what is happening to people. In the development of any new models, we need to make sure that people are not effectively out of sight. That is the only thing I would say. That is the concern I have. That is something that can be pretty easily addressed, I think, in giving permission for a variety of new accommodation models to be established.

CHAIR: Dr Chesterman, we have come to the end of our session. I thank both you and Ms Martell for your work, for your guidance and for what you do on a daily basis for Queenslanders, especially our most vulnerable. Thank you very much for your time this morning and we certainly look forward to working with you more closely as we progress through the inquiry.

Dr Chesterman: Thank you, and thank you to members of the committee.

CHAIR: We have two questions on notice. One is for you to email if possible the person-centred standards, and your top five priorities. The due date for a response to those is 20 December, if possible. If there is any issue with that, please let me know.

Dr Chesterman: Thank you.

CURRIE, Ms Jody, Director, Regional Services Central, Public Trustee of Queensland

SOMMERS, Ms Elaine, Acting Principal Advisor, Governance, and Disability Support Officer, Public Trustee of Queensland

CHAIR: Good morning to you both. We would like you to make a brief opening statement at your leisure. We will then follow on with some important questions to clarify both your submission and your statement. We thank all Public Trustee staff for the work that they do every day.

Ms Currie: Thank you for the invitation to attend today's hearing. The Public Trustee is appointed as financial administrator for adults with impaired decision-making capacity under the Queensland Guardianship and Administration Act 2000 and acts as a financial attorney under the Queensland Powers of Attorney Act 1998. The Queensland Public Trustee provides services to some of our most vulnerable members in Queensland, acting as financial administrator or financial attorney for approximately 10,000 adults with legal cognitive incapacity. A portion of Public Trustee customers reside in supported accommodation; however, the Public Trustee cannot readily identify all customers who may fall into this category given that these customers are highly vulnerable, moving between facilities and inpatient care or experiencing periodic homelessness. The Office of the Public Advocate has highlighted some systemic issues relating to the standards of accommodation, food and service provided to residents. The Office of the Public Advocate invited the Public Trustee to provide input into the research phase of its report.

The impacts on our customers living in supported accommodation facilities include: it may not allow sufficient disposable income to improve their quality of life; there may be insufficient personal spending for purchases such as clothing, medication and toiletries; customers potentially pay twice for a service; and customers' personal spending is at times paid to the facility. Therefore, at times our customers may choose to leave these facilities and may choose homelessness to allow them to meet their personal needs such as tobacco purchases and choice and control of their personal spending amounts.

The Public Trustee sees significant inconsistencies between what service providers charge and what is outlined in the rooming agreement. At times the rooming agreement would indicate that they are provided level 3 supported accommodation; however, no personal care services are identified in the agreement. In our experience, most customers living in level 3 supported accommodation would be entitled to funding through other government agencies such as NDIS, aged-care funding, home care packages and Queensland community support services to meet their care and support needs.

A review of a small sample of customers living in these facilities shows they are charged for items such as medication management, cleaning, laundry, meal preparation and administration management fees. These expenses outlined in the rooming agreement could be considered daily living support and funded through other government programs. While the Public Trustee utilises a structured decision-making process to inform the financial decisions about supported accommodation costs, the Public Trustee does not have consistent access to details of individual customer's government funded disability and support services provided via the NDIS, aged-care funding, DVA or other services to inform their financial decisions about tenancy costs. It is likely that a significant number of people residing in supported accommodation experience complex support needs and impaired decision-making ability, and engage with services across a range of government organisations including the Public Trustee.

The legislation in Queensland does place an emphasis, in some parts, on promoting and safeguarding the adult's rights, interests and opportunities in a way that is least restrictive of these rights, interests and opportunities. The Public Trustee highlights that the increased clarity of fees for care and support services charged by a supported accommodation provider will help the Public Trustee to engage more transparently in the supported decision-making process with this vulnerable customer group to ensure that the customer is not self-funding services where government agencies also provide the funding to support the accommodation provider for the same service.

CHAIR: I turn to the deputy chair to ask the first question.

Mr BENNETT: You mentioned some charges and other issues that some of the residents are talking about. The Public Advocate's report talks about there being no regulation or control over how much different facilities use. Can you talk to us a bit about how you manage that on behalf of clients?

Ms Sommers: Sure. At the Public Trustee our responsibility obviously relates to our customers' financial matters. We would be responsible for signing a rooming agreement on their behalf. The rooming agreement should outline the cost of the accommodation, food and care and

support services provided. In the current regulation, if all three of those services are provided, it fits the bill of being level 3 supported accommodation. We are seeing great variability in how those costs are broken down for each of those specific services. We had a look at a snapshot of a number of our customers' rooming agreements in preparation for today just to get a feel for what we are looking at. We are seeing that a lot of the rooming agreements indicate that they are residing in a level 3 supported accommodation facility—not a level 1 or 2—but they are not outlining the costs for care services. The rent component is always going to be the most significant component of that rooming agreement and then the meal service and the care and support services. Those are the three arms of a rooming agreement for level 3 supported accommodation.

We are seeing great variability between different providers as to what they charge. For quite a number of the rooming agreements there were no costs associated with care and support services while they were still residing in level 3 supported accommodation. I think we had costs between, say, $800 and $1,000 fortnightly for living in these facilities. The majority was the rent component, and there were no costs for care services. It becomes really difficult for us to manage that because we do not know how they are coming to that breakdown. Some document it really well and some do not. When we looked at the 46 level 3 supported accommodation facilities, we have customers living in every single one of them. We do not hold numbers specifically. That is something we could drill down in our system and find, but it is not something on which we regularly report.

Mr BENNETT: Do you have knowledge of how your customers may access NDIS? Is that done separately? Could that be part of the care services that they are accessing?

Ms Sommers: Yes. The difficulty we have at the moment is that the NDIS is not recognising our authority as a decision-maker. We do not necessarily have visibility of our customers' NDIS plans. We do not know if care and support services are funded under an NDIS plan and delivered in a level 3 supported accommodation facility. They may have a charge on their rooming agreement for care and supports, but they also may be an NDIS participant or receiving other government subsidies and we do not have visibility about what services are funded by those programs. There could be double dipping; we do not know. We still have to sign, but we do use a supported decision-making framework. We will be having those discussions with our customers about what services they are receiving. They may or may not choose to disclose that information to us. The NDIS will not share it with us. That makes it incredibly difficult.

CHAIR: Deputy Chair, do you have anything else?

Mr BENNETT: No. We could go on about that all day, but we might move on.

Ms Sommers: It is whole other matter, isn't it?

Mr BENNETT: I guess it is more for us to drill down into that.

CHAIR: Absolutely. Ms Sommers, would that requirement or lack thereof sit under the NDIS Act federally or another federal act?

Ms Currie: It is under the NDIS Act. It is their legislation that does not allow NDIS to share that information with us. We are in consultation with the NDIA and have been a part of some of the inquiries into that and making submissions around those challenges.

CHAIR: Great. That gives us the information we need. I was not sure whether it came under the Information Privacy Act federally or if it came under the NDIS Act.

Mr SKELTON: Following on from the conversation that we have been having, you referred to the federal government and the state lining up in terms of the NDIS. To better perform the duties of your office, what sort of regulatory reforms would you like to see?

Ms Sommers: One of the main ones, which is at the Commonwealth level, is our having visibility around NDIS plans. Where the Public Guardian is involved, they will share that information with us, but, for example, we have around 10,000 customers to whom we provide a service and the Public Guardian has around 3,000. A lot of our customers do not have a guardian and we may not have visibility of that information. Having that recognition of our right to information to make decisions or support our customers to make decisions around their accommodation costs would be very useful for us. That is something we have submitted to the NDIA. There are discussions happening at that level as well.

Mr MOLHOEK: We have been touching on issues around the NDIS and NDIS clients. Have you done any work or investigation into the relationship between NDIS clients and the service providers in respect of looking at accommodation and other services?

Ms Sommers: From our experience—and as Dr Chesterman referred to earlier—a lot of the level 3 supported accommodation providers also have an arm of services that are NDIS providers as well. They may well be residing in level 3 supported accommodation. Depending on the individual, they may have engaged an external provider for their NDIS funded services or they may be wrapped up with the provider who is their supported accommodation provider. Again, we would not have visibility on that because there are no financial decisions to make around that as the NDIS funds do not fall under our authority.

Mr MOLHOEK: Are you aware of or have you seen many examples or occasions where NDIS clients are just blankly being ripped off by the service provider—they are paying more fees than they are rent?

Ms Sommers: There is one I can think of where the supported accommodation provider basically offered our customer to stay in the level 3 supported accommodation for free if he chose them as his NDIS provider. The NDIS funds are often a much bigger portion of money—they could be hundreds of thousands of dollars. We have seen where they are enticed to stay with a specific level 3 supported accommodation provider rather than, say, move into supported independent living, SIL, accommodation where their need may be more appropriately met by saying, 'We are not going to charge you to live here, but we will be your NDIS service provider.' We have seen instances of that.

CHAIR: Thank you, Ms Sommers. Member for Southport, we just need to be very cautious around using inferencing and inferences when questioning witnesses.

Ms PUGH: For the benefit of today's witnesses, I am filling in for Cynthia Lui. I will use this opportunity to declare that I have a brother-in-law who lives in supported accommodation. That is something that I declared at the private hearing as well. My question follows on from the member for Nicklin's question around the kinds of reforms that you think need to happen. I am very clearly hearing that there is some work that also needs to happen at a federal level in order to bring this all together in the most beneficial way. Can you outline for the committee broadly what work needs to happen in order to either streamline or create more transparency or both for you doing your work and for the benefit of people living in all levels of assisted accommodation?

Ms Sommers: I think Dr Chesterman's report speaks to regulating the fees and charges. That would certainly make our decision-making process a lot simpler. When you see someone who is in level 3 supported accommodation and 90 per cent of those costs are going towards rent and you are talking about $700 or $800 a fortnight in rent for a shared bedroom and a shared bathroom, that does not seem to me to be reasonable when they provide that breakdown on the rooming agreement. I think more regulation around those costs and how they are charged and visibility about what the care and support services are is needed. I have seen, for example, some rooming agreements when we did our little snapshot where $800 might be the rent component for a fortnight and there is only $100 for food for the fortnight. It does not seem to be commensurate with the service they are receiving that a shared bedroom would be $800 a fortnight in rent. I think some regulation around what the providers can charge is required.

With the NDIS, for example, in the SDA, supported disability accommodation, price guide they regulated it as percentages of their pension and that would definitely bring some visibility. The concern is because we do not have visibility around what is funded by other services—NDIS, DVA or aged-care packages—and are those actually being provided by the level 3 service provider? In terms of a lot of those daily living supports, if someone is an NDIS participant there would be funding in their NDIS plan for that but we do not know.

Ms PUGH: You used the word 'visibility'. Obviously we can have visibility where the client can see, but are you also talking about potential visibility within the marketplace, if that is what we want to call it, so that it is publicly available? Is that also what you are referring to? I do not want to verbal you; I just want to be clear about when you say 'visibility' who that is visible to.

Ms Sommers: Visibility around what services are costing within that rooming agreement is what I was meaning. It is more visibility around what is the rent component, what is the food component, what is the care services component and then visibility around what services are they already getting funded by other services and is that a reasonable cost for care services if they are, in fact, being provided by another entity, provider or funding body.

Ms Currie: Just to build on that, part of the disability support officer's role is to look at what other funding might be out there for our customers to maximise their personal spending and so they are not having to self-fund. If we have that visibility on the rooming agreement around those breakdowns and they are getting charged for a certain service, we can have a look to see if there is another way they can get that funding so they do not have to pay for that.

Mr BENNETT: In terms of the discussions we are having about visibility or the rooming agreements, I am wondering about the statistics. Outside of assisted living, if we pay 30 per cent or more for a mortgage we are considered to be under housing stress. Then that is put through the ABS housing affordability comments. Would most of the clients be seen to be in that sort of stress area? I am hearing the figures you are talking about and they are quite considerable weekly or fortnightly rents. I am trying to gauge what this means. We have had the conversation about should it be transitional. Should clients be staying there for long periods of time? I guess it is all relevant if they are paying significant parts of their income through whatever mechanism that is.

Ms Sommers: Yes, absolutely. Typically with Department of Housing or social housing we are looking at 25 per cent of the pension plus Commonwealth rent assistance where they are eligible and, for SDA, supported disability accommodation, within the NDIS they also charge that amount. I think that is a fair proportion; you are under that 30 per cent threshold. What we are seeing is our customers have very limited funds left in their budget. We are talking about a budget surplus of maybe $10 a fortnight, if that, because they still have to pay for their medication, clothing, haircuts—all personal items—and we are seeing very limited funds left available for that. When you are seeing a rooming agreement where it is significantly more than 25 per cent of your pension and your rent assistance is directed just towards the rent component of the accommodation, that seems a bit excessive. For example, the NDIS SDA guidelines indicate the 25 per cent of the rent plus your Commonwealth rent assistance. Then if you are getting full board, which is inclusive of your utilities, that is 50 per cent of your disability support pension. You are looking at that 75 per cent threshold and then having 25 per cent of your income left over for whatever you want to spend it on. I guess we are not necessarily seeing that in level 3 supported accommodation where up to 85 per cent or 90 per cent of your income can be taken up in your rooming agreement and costs.

CHAIR: Ms Sommers, does the Public Trustee have a complaints process in that situation? Is there a means of managing any complaints that might come through in relation to that?

Ms Sommers: We have our own independent complaints process for the Public Trustee but in terms of us complaining about the costs of level 3 supported accommodation—

CHAIR: On behalf of your—

Ms Sommers:—on behalf of our customers?

CHAIR: Yes.

Ms Sommers: Not really. We will try to negotiate if we think it is too much given the other costs that the customer may have, but it is not usually something that is that negotiable. I do not know that there is a complaints process that you could go through because it would be through the individual provider.

CHAIR: For a client in that situation, what is their pathway to complain?

Ms Sommers: I would not really know. If we have signed a rooming agreement, we have agreed that those costs can be covered. Then often the complaint is the customer wants more money but they just do not have it. The complaint probably then comes through to us that they do not have the disposable income for the necessities they need such as their medication—we will always prioritise medication costs. A lot of the clients who reside in level 3 supported accommodation are smokers and their tobacco costs are significant. Usually what we are seeing is by the time medication, board and lodgings, and tobacco are paid there is no money left.

Ms Currie: I think this is what it comes back to: our structured decision-making capacity and giving the options to the customer. If the customer is wanting more money and they do not have that money available, it is having that budget conversation with them. This is where sometimes our customers choose to leave that facility. That is why it is quite difficult to ascertain how many customers at any given time we have living in those facilities because they will choose homelessness, they will couch surf or they will move so they can have their personal spending money of maybe $10 a week increased to $100 a week if that is what they are choosing.

CHAIR: Does the Public Trustee have any data on the degree of homelessness amongst level 3 clients?

Ms Currie: Whether they are homeless or not, we do record if a customer does not have a forwarding address or a current address. We do put them care of the Public Trustee, so we can confirm that. We would have to drill down as to whether they have been in level 3 before or not.

CHAIR: Is it possible for the Public Trustee to provide the committee with any data or information you have about the percentage of homeless in Queensland who may be level 3 accommodated potentially?

Ms Currie: Yes.

Mr SKELTON: Obviously it is problematic when dealing with federal and state legislation and you also point to having that model like social housing where it is pretty much up-front what they can charge in terms of a percentage of what the person has in their package or pensions et cetera. You have no visibility with the NDIS but you also mentioned DVA. The reason I bring that up is there are a lot of people on DVA cards at this sort of accommodation. You do not get any visibility with that, either?

Ms Sommers: It is only when we are getting a request from a customer who is asking for additional funds for what may be a disability related need that we would then look at what other funding options are available to them. Do they hold a DVA card? Is this something that could be funded under DVA? When we are looking at signing a rooming agreement, we are really looking at that specifically, not the care and support services necessarily because someone, either the customer themselves or a guardian, has made a decision on their behalf that that is where they are going to be living. That is a difficult one in that when a specific request comes through for something that might sit outside of that, we will go looking as to what other services are they likely to be receiving.

We are kind of stuck a little bit in that if residents are not in a level 3, you lose the visibility of the Community Visitor Program going into that facility, whereas realistically if they are getting their care and support services funded by another entity such as the NDIS most of them would probably sit on that level 2 residential service, not the level 3. Because they do not need the care and supports, they are not having to self-fund those. Then you lose the visibility of the community visitor going into the facility and having that oversight and that protection for those vulnerable people. It is a really tricky one. We just have to say, 'Is this accommodation cost affordable and what services?' Most of the level 3 provide medication management. Like I said when we did our snapshot, what we were seeing was most of them are ticking level 3 but not putting a cost for the care services or the support services in that rooming agreement. They are just limiting it to the rent, the meal service and the food. That is difficult.

CHAIR: I would assume the majority of clients would have a healthcare card?

Ms Sommers: Yes, the majority would be on a Services Australia pension.

CHAIR: Thank you. Ms Currie and Ms Sommers, you have both been incredibly helpful to the committee. Again, as public servants and our frontline workers in Queensland—your staff—we greatly appreciate all that you do for our most vulnerable Queenslanders. We know that the work you do is incredibly valuable. We appreciate what you do for those Queenslanders and for those who live in supported accommodation across the state. There was just one question on notice about the data in relation to the level of homelessness amongst clients. I appreciate that might be difficult to provide but it certainly would assist the committee. Thank you so much. I now invite the next witnesses to the table.

SMITH, Ms Shayna, Public Guardian, and Chief Executive Officer, Office of the Public Guardian

CHAIR: Ms Smith, welcome to the committee. We thank you for your submission. The committee very much values what we have read and we thank you for your contribution to our inquiry. I will hand over to you for a brief opening statement followed by some important questions led by our deputy chair.

Ms Smith: I thank the committee for the opportunity to appear before you today. I would like to begin by acknowledging the traditional custodians of the land on which we meet today, the Yagara and Turrbal people, and pay my respects to elders past, present and emerging. I would also like to acknowledge the important work of the Public Advocate in identifying and advocating for reform on systemic issues impacting adults with impaired decision-making capacity. I welcome this inquiry into the provision and regulation of supported accommodation in Queensland.

The Office of the Public Guardian is an independent statutory office. We promote and protect the rights and interests of adults with impaired decision-making capacity. We also promote and protect the rights and interests of children and young people who are in the child protection system or staying at visitable sites. Relevant to this inquiry, the office provides guardianship, investigation and community visiting services to adults with impaired decision-making capacity. This includes providing decision-making services for personal matters. You have just heard from representatives of the Public Trustee, who may provide decision-making services for financial matters. The Office of the Public Guardian is appointed by the Queensland Civil and Administrative Tribunal on behalf of an adult to support their decision-making and personal matters. It can also be appointed as an attorney under an enduring power of attorney or we can make decisions as statutory health attorney of last resort.

We provide investigation services into allegations that an adult with impaired decision-making capacity has been or is being neglected, exploited or abused or has inappropriate or inadequate decision-making arrangements. We also provide oversight services whereby community visitors visit certain sites to identify, escalate and resolve complaints by or on behalf of residents staying at those sites. A visitable site is defined in the Public Guardian Act. It does not include a private dwelling house or an aged-care facility; however, it does include places such as authorised mental health services, the Forensic Disability Service, places where certain NDIS participants reside and receive specified classes of support and, as you have heard, level 3 residential services.

For level 3 residential services the purpose of a visit is to protect the rights and interests of those adults with impaired decision-making capacity who live and receive services at that site. Community visitors perform inquiry and complaint functions in relation to those sites. The inquiry functions relate to the adequacy and accessibility of information that is available for adults about their rights and complaint mechanisms and the appropriateness of the services that are being delivered.

The complaints function relates to inquiring and seeking to resolve complaints and making referrals to relevant external agencies to resolve their issues. In level 3 residential services this could include: the Department of Housing, the NDIS Quality and Safeguards Commission, Queensland Health for both general and health concerns, the Queensland Police Service if a criminal offence is suspected and the Queensland Human Rights Commission.

In 2022-23 the Office of the Public Guardian made 129 visits to level 3 residential services. Community visitors provide a scheduled visit to level 3 services every six months or every three months where issues have been identified as requiring more frequent visits. Currently, the Office of the Public Guardian visits 20 of these sites on a six-monthly basis and a further 13 sites on a quarterly basis. Community visitors can also provide a visit at the request of an adult or another person on their behalf—for example, an advocacy organisation. From the period 1 January to 22 November this year community visitors raised 155 issues on behalf of adults residing at level 3 residential services.

The Office of the Public Guardian also, as I outlined, provides guardianship services which interact with level 3 residential services. We can support adults residing there with their decision-making. There are approximately 132 adults who have the Public Guardian appointed for decision-making residing at a level 3 residential service, which represents about 3½ per cent of our overall guardianship clients. Guardians generally only support decisions for people to reside in level 3 residential services when there are no other accommodation options available or where the person is very clear that they wish to reside at a specific service. Residential services are an option when there is a need for urgent accommodation—for example, in circumstances where a person requires an urgent bail address or application, has been evicted from living elsewhere, or otherwise has become homeless. Level 3 residential services play a role in the provision of accommodation to

support both NDIS and non-NDIS participants who may or may not have a cognitive impairment, although we do understand that those with impaired decision-making capacity are a particularly vulnerable cohort.

I would just like to close by saying that, while we remain in the midst of a housing crisis, level 3 residential services do play a role in providing an accommodation option. I welcome this inquiry as an opportunity to address the issues experienced by residents and to reform the model in line with relevant recommendations of the disability royal commission to provide accessible, secure, appropriate and safe accommodation.

CHAIR: Thank you, Ms Smith. Your contribution is much valued and very important to the committee.

Mr BENNETT: You did mention some of the visits you do. Did I hear correctly that statutorily you visit every six months and then on top of that it is complaint driven?

Ms Smith: The legislation says it is a mandatory requirement to visit regularly. We also visit children who are in out-of-home care and residing at visitable sites such as youth detention centres. We schedule the frequency of visits based on the priority of need and risk. At the moment, with resourcing, all level 3 residential services are scheduled for six-monthly intervals but of course that can be more frequent if issues arise. If there is a really significant concern it can be more frequent than that. As you say, we can be asked by other parties to visit, and we really encourage residents to contact a community visitor to request a visit if they need that. In the last year I believe 20 residents requested an unscheduled visit.

Mr BENNETT: I believe the Department of Housing would determine if it is low-, medium- or high-risk. Does the Public Guardian have any role to play in the quality improvement plans that are implemented? If there are issues do you have any input into what those improvement plans might look like?

Ms Smith: I would say that community visitors are an oversight, so they are not the regulator.

Mr BENNETT: Which is the Department of Housing?

Ms Smith: Yes, that is right. In line with the Residential Services (Accreditation) Act, the Department of Housing has the core function of monitoring and compliance as a safeguarding and oversight mechanism. Community visitors are a point-in-time check and balance that the services being delivered to residents are appropriate. They would speak directly with residents, and if there are concerns they would raise that issue and refer it to the appropriate agency for resolution. No, they would not be intimately involved in compliance activities or setting those plans by the core agencies that have the monitoring and compliance function.

Mr BENNETT: I am sorry if I misunderstood. Public Guardian staff would not necessarily be down at the improvement plan level?

Ms Smith: No. If a resident raised a specific issue in relation to that matter, they may. If there is an agency that has the responsibility for regulating that particular issue, they would raise that and refer it. Yes, if something is raised of course they would need to get across the issue to understand. It is a very complex regulatory environment so they have to be really a jack-of-all-trades, understanding Commonwealth- and state-based regulation, mental health, housing, general health, restricted practice and disability. They would need an understanding of the particular issue.

Mr SKELTON: Youth detention centres are a type of supported accommodation and you have some visibility there. Could you elaborate on what the Public Guardian does there in terms of the rights of people within those facilities?

Ms Smith: Are you talking about young people in detention centres?

Mr SKELTON: Yes.

Ms Smith: It is a visitable site under the legislation, so our community visitors would regularly visit. It is a similar role. Under the Public Guardian Act there are separate provisions around what community visitors do in relation to children and young people, but it is essentially very similar in terms of upholding the rights and interests of young people staying at those places.

Mr MOLHOEK: How does the Public Guardian operate in terms of the services you provide? Do you get paid for these audits, visits and services, or are you fully funded by the state government? How does it actually work?

Ms Smith: Yes, all of the services are funded by the state government. Our community visitors, because they are those independent eyes and ears, are actually appointed by the Public Guardian under the Public Guardian Act, but they are public sector employees. They have recently been brought under the Public Sector Act. They still have that level of independence. Yes, it is funded by the state government.

Mr MOLHOEK: They would just be remunerated through normal salaries and wages or working conditions?

Ms Smith: The majority of our community visitors are a casual and remote workforce because they need to travel to visit either the children or adults we visit. Under the new Public Sector Act they had the ability to convert to permanency, and some have chosen to do so. The remaining employees of the Office of the Public Guardian are public servants.

Mr MOLHOEK: What is the recruitment process for those people? What are you looking for? Is there a minimum standard of education or is it based on CV and experience?

Ms Smith: Our community visitors are an amazing, diverse workforce and the flexibility of the role attracts a wide range of people. We have community visitors who are former ombudsman staff, former child safety staff, or have experience in the non-government sector in terms of disability or child protection. There is such a broad spectrum. We do not have any mandatory qualifications, but we do really look for those skills—it is essentially a monitoring inquiry; being able to enter a place, being able to have conversations with the people they are visiting, also looking at the surroundings, talking to people and getting a sense of what might be happening at that site.

Mr MOLHOEK: In some of those smaller rural and remote settings, and possibly even some of those smaller First Nations communities, do the people recruited come from out of town? Do they come from within the community? How do you ensure they perhaps do not have other conflicts or ties with the community?

Ms Smith: That is always a challenge. We do try and recruit all over Queensland, but obviously there are some areas where it is more challenging. Mount Isa, for example, is one of those regions. Where we cannot recruit from local areas, our community visitors will travel. A lot of their role is travelling to people. It is a person-centred service, so we deliver the services to the person or at the place.

Mr MOLHOEK: How many community visitors are there in Queensland—as in full-time equivalents perhaps?

Ms Smith: We are funded for around 60 full-time equivalents, but that is for over 10,000 children and young people we visit and also for adults with impaired decision-making capacity who may reside at the sites I outlined earlier. It ebbs and flows a little bit with recruitment, but there are up to 100 community visitors across Queensland.

Ms PUGH: I just wanted to ask about the timeliness of decision-making for your office around after-hours, weekends and that sort of thing and how you manage those issues.

Ms Smith: Do you mean for our guardians, or do you mean for visits by community visitors?

Ms PUGH: What is the process for managing issues that arise out of hours, because I suppose when there are issues in supported accommodation they are not all happening nine to five, Monday to Friday?

Ms Smith: Our guardians do work within business hours, but it is not uncommon for something to happen at 4.30 pm on a Friday afternoon and they will just remain in the office to try and manage that crisis situation.

Mr BENNETT: We have heard from the Public Advocate and the Public Trustee about some of the issues with the NDIS in terms of transparency. Does the Public Guardian or your people on the ground have any observations in terms of confusion about the NDIS and other payments?

Ms Smith: As I said earlier, this is where the regulatory complexity is really evident. The Public Trustee has visibility over the finances. Our guardians support decisions about personal matters—accommodation, health care, service provision and so on. We do work closely with the Public Trustee, but our guardians would not be monitoring the drawdown of funds for example under an NDIS plan. The majority of plans for people who may be NDIS participants and for whom we are appointed Public Guardian are managed by the NDIA. They would be monitoring that.

Mr BENNETT: Would the delivery of services that some of the clients may or may not be getting be a clear remit of the Public Guardian?

Ms Smith: If they had the Public Guardian appointed as the guardian to support decision-making, we would assist with decisions around who would be appointed to provide those services and depending on what they are funded for under the NDIS plan, but it is very confusing. We would absolutely say that it is grey in terms of knowing with clarity whether a level 3 residential service is operating as an NDIS provider, a level 3 residential service or both. Therefore, there are different obligations that apply for each of the hats that they wear to deliver all of the different services.

Mr BENNETT: In terms of the ones we are looking at in this inquiry—level 3, level 2 and level 1 service providers—how many clients would you have under guardianship across Queensland?

Ms Smith: I believe it is around 150, so probably around 10 per cent of the total number of residents in level 3 services.

Mr BENNETT: How do they come under guardianship?

Ms Smith: If someone has a concern about their capacity to make complex decisions, they may apply to the Queensland Civil and Administrative Tribunal.

Mr BENNETT: Can that be family as well?

Ms Smith: The Public Guardian is only appointed as a guardian of last resort. While we may be appointed for 10 per cent of that cohort, many more may have family members appointed as a formal guardian or their capacity may be of a level where they can be supported to make their own decisions.

Mr BENNETT: Thank you for that clarity.

Ms PUGH: I recognise that this may be a little bit out of your bailiwick and a little bit out of left-field but, as a visitor to a lot of these facilities, I am curious to know. There has been a bit of discussion this morning about the different models, how much privacy homes could or should have and bit of recognition that different things work for different people. I also mentioned that my brother-in-law lives in supported accommodation under the NDIS. From your visitations, do you have any observations about what models work? What are some of the key features that lead to more harmonious living? Are there any other observations that you wanted to share with the committee around that seeing as you have quite a breadth of experience across your workforce?

Ms Smith: If you look at what gap the level 3 residential services are filling in the housing market. Who are your residents and why are they there? I think that that will indicate the types of support models that are required. Essentially, are they there because there is a lack of options? Is it their will and preference perhaps to live in social housing, or is it their will and preference that perhaps they would like to live in appropriate disability accommodation but the market and the development has not quite kept up with the pace of the NDIS? Is it that it is being used as emergency accommodation or is it even in a step-down sense? Are they transitioning from a correctional facility? Are they transitioning perhaps from a mental health facility? Looking at what those cohorts and their needs are may provide some answers into the models that would be fit for purpose for those people. It may be that they need to be extensions of those other service systems. Does that help at all?

Ms PUGH: I think so; absolutely.

Ms Smith: It is not a homogenous group so it is very difficult to say what model will fit. Everyone has very different complexities and needs. I am sure residents themselves will probably be able to inform you of what they think they need is not being provided at the moment. This group and their complexities cut across a multitude of different government services at both the Commonwealth and state level. It is very difficult to have one size fits all.

Mr BENNETT: Recently, we visited a site in the wonderful Mansfield electorate—it was quite enlightening—and there were some advocates with us who seemed to have a quite intimate relationship with the residents. Are we relying on those people to ensure that the residents can find your services or other stakeholders? It seems that this is complex and a little bit fragmented, to be fair. That is a comment. I am not asking you to comment on that. Do those advocates find the clients and connect you?

Ms Smith: We do work closely with the advocacy agencies, absolutely, because they really have that ability to be flexible on the ground and actually work across a multitude of issues. Earlier, Dr Chesterman spoke about the need for that single point of assistance that might be akin to case management. I think that is because at the moment we know that a lot of services are funded for specific reasons. You might have an agency that can assist with a housing matter or an agency that can assist with a mental health matter—it is very siloed—whereas we find if the advocates are

provided that generalist funding they can assist that person with all of those issues that intersect, because no-one ever has one standalone issue. We do find that very beneficial. We work closely with them. Yes, we can make referrals to independent advocates for people if they agree.

Mr BENNETT: How are the advocates we met engaged and employed?

Ms Smith: Are you talking about from community organisations?

Mr BENNETT: We have met a couple of advocates. Do we know from where they originate?

Ms Smith: When I talk about advocates, I am talking about the community organisations.

Mr BENNETT: Okay. Thank you for that.

CHAIR: Some of which would be government funded.

Ms Smith: Yes, they receive government funding but they would be non-government organisations.

CHAIR: It would be through the department of communities I would imagine, Deputy Chair. In his report the Public Advocate described the social model of care versus the housing model. Do you have any thoughts about that suggestion or about his work?

Ms Smith: I do not think the two cannot coexist. What we have seen come out of both the disability royal commission and the independent review of the NDIS is that quality is very important. It is about having a robust set of standards or even a modernised legislation that puts people's rights at the forefront rather than a 'best interest'. Since the United Nations Convention on the Rights of Persons with Disabilities, we are now reframing legislation in terms of rights and people's will and preference. I know that there is an opportunity on the horizon for a review of the legislation, but if it were reframed to put people's rights at the forefront, supported by standards that also go to quality and then underpinned by a strong regulator with a wide range of tools and resourced well, I think it would go a long way towards the prevention of harm.

CHAIR: Thank you. We really appreciate the time that you have taken out of your busy schedule. Thank you for all that you do for Queenslanders. The committee certainly very much appreciates working with you. Thank you and we wish you a good day.

Ms Smith: Thank you very much.

Proceedings suspended from 10.40 am to 11.01 am.

CHAIR: The public hearing will now resume. I welcome the next witnesses.

GALER, Mr Sam, Principal Project Officer, Housing Legislation Amendment Team, Residential Tenancies Authority

MOLLER, Ms Katherine, Manager, Strategy and Government Relations, Residential Tenancies Authority

SPRUCE, Ms Kristin, Acting Chief Financial Officer, Residential Tenancies Authority

CHAIR: Good morning to all three of you. We thank you for appearing before the committee this morning. We will ask that you make a brief opening statement after which our committee will have a number of very important questions.

Ms Spruce: Good morning and thank you for the introduction. My name is Kristin Spruce and I am the Acting Chief Financial Officer at the Residential Tenancies Authority, the RTA. Firstly, I would like to respectfully acknowledge Aboriginal and Torres Strait Islander peoples as the traditional owners and custodians of this country. We recognise the continuing connection with the lands and seas on which we meet, live, learn and work. We pay our respects to all traditional owners and their elders past, present and emerging.

I thank the committee for the opportunity to attend and represent the RTA at the committee's inquiry. The RTA provides free tenancy information, support, bond management, dispute resolution, and compliance and enforcement activities to the one-third of Queensland households who rent. The RTA administers the Residential Tenancies and Rooming Accommodation Act 2008, which I will refer to as the RTRA Act, which outlines the obligations for tenants, managing parties and owners as well as for residents and providers involved in rooming accommodation agreements.

The RTA is an impartial statutory authority that provides services to the one-third of Queenslanders who rent. We administer the RTRA Act and work with the Department of Housing, which leads any legislative reform. The RTA does not set policy. However, it provides insights to the Department of Housing on the practical implementation of the RTRA Act and the impact it has on Queenslanders.

The RTRA Act covers general tenancy agreements and rooming accommodation agreements. Rooming accommodation agreements cover certain types of supported accommodation. Generally, rooming accommodation is where a resident has the right to occupy one or more rooms, does not have a right to occupy the whole of the premises in which the rooms are situated, does not occupy a self-contained unit, and shares other rooms or facilities outside of the room. This means all supported accommodation service providers, excluding those provided under the Supported Accommodation Assistance Program, must enter into a rooming accommodation agreement with a resident renting a room on the premises if they have occupied the residence for longer than 13 weeks.

The RTA's stakeholder forum, which has a focus on strategic discussions, and the RTA stakeholder working group, which focuses on communication and education initiatives, provide an opportunity for the RTA to partner with peak industry bodies and representatives to discuss issues and trends affecting the sector. The RTA works directly with the Supported Accommodation Providers Association, SAPA, to understand the challenges providers and their residents face. A key role of the RTA is to assist accommodation providers, managers and residents to understand the rights and responsibilities under the RTRA Act. In recent years the RTA has collaborated with SAPA to develop and deliver a range of new tenancy information resources including an educational webinar; two whole-of-tenancy checklists for providers, managers and residents; and a series of information pages available on the RTA website.

The RTA engaged with SAPA and other stakeholders in the rooming accommodation sector to ensure their feedback was reflected in a review of the rooming accommodation agreement, the R18. A key improvement was the inclusion of more specific information on the breakdown of rent and other services. The RTA recently attended SAPA's annual general meeting and reminded providers that minimum housing standards are now in place for new and renewed tenancies and will come into effect for all existing tenancies from 1 September 2024. The RTA also promoted the recently updated managing rooming accommodation guide that supports providers and managers in understanding their rights and responsibilities under the RTRA Act.

The RTA, through its stakeholder working group, invites member organisations such as SAPA and Queenslanders with Disability Network to regularly provide suggestions and to review draft external communications and educational materials to ensure the RTA resources are accessible to

the diverse needs of our customers. The RTA appreciates the partnership and engagement we receive from all industry bodies across the sector. The RTA acknowledges the recently released Public Advocate's report, the role it played in establishing this inquiry and the focus on level 3 residential services known as supported accommodation and their arrangements in Queensland. This includes rooming accommodation agreements covered under the RTRA Act. The RTA would like to take this opportunity to share some high level information that it collects in relation to supported accommodation.

As at 30 June 2023 the RTA held 1,121 bonds for residents in supported accommodation. This represents 0.18 per cent of all bonds held by the RTA. In the 2022-23 financial year the RTA received 546 calls and conciliated 29 disputes related to supported accommodation. The most common topic for disputes and calls was bond related. On behalf of the RTA, I thank the committee for the opportunity to participate in the committee's inquiry into the provision and regulation of supported accommodation in Queensland.

CHAIR: Thank you, Ms Spruce. Your submission from the Residential Tenancies Authority has been very helpful, so we thank you for that.

Mr BENNETT: You may have answered it but I might have missed it. I want to flesh out the rooming agreement and tenancy agreements. I think you mentioned that it is because it is only a single room; is that the simple explanation for why rooming agreements are more prevalent in level 3 assisted accommodation? I think you mentioned something like that, but I am a bit slow on the uptake I guess.

Ms Spruce: Generally rooming accommodation is where a resident has a right to occupy one or more rooms but generally not the whole unit or a self-contained unit in other rooming accommodation compared to a tenancy agreement where the tenant would have sole occupancy of the whole unit.

Mr BENNETT: With rooming agreements, a tenancy would provide more protection for a client than a rooming agreement; would that be fair to say?

Ms Spruce: Rooming accommodation agreements have very similar protections to the tenancy agreements. However, there is also an opportunity for the residents or tenants to opt into a tenancy agreement with a supported accommodation provider.

Mr SKELTON: With regards to that, can a tenant choose to enter into either a tenancy agreement or a rooming accommodation agreement, or would this be subject to the provider agreeing to this sort of agreement? In other words, it would have to be negotiated?

Ms Spruce: Generally parties would have to agree to what type of agreement they would enter into. If there are any concerns around what type of agreement they may have entered into, the parties are able to take the matter to the Queensland Civil and Administrative Tribunal for a decision on this and the coverage of the agreement.

Mr MOLHOEK: This is probably the same question I posed earlier. In our quest to support the rights and responsibilities of tenants, how do we get a better balance between the rights and responsibilities—just the practicalities of delivering services across-the-board? All of these rights and responsibilities in these agreements create the potential for barriers for people who are looking to get into the market and provide services. A lot of people do not get into the space because they say it is all too hard. Have we got the balance right? Do we have too many regulations? Could we change the regulatory environment to make it more flexible but create some other entity or body to look after the potential exploitation of tenants or individuals?

Ms Spruce: The RTA, as I mentioned earlier, is an impartial statutory authority that provides services to Queenslanders who rent and residents. We administer the RTRA Act and work with the Department of Housing, which leads any legislative reform. As mentioned before, we do not set policy. As the department leads the legislative reform of the RTRA Act, the department might be better suited to answer this question. We support all residents and all service providers through any inconsistencies or disputes within the supported accommodation services. We have targeted support networks and also specialised—

Mr MOLHOEK: Perhaps I could rephrase the question because this is a public inquiry. I understand what your job is. The purpose of this is how do we provide more and better supportive services to Queensland? The question is: from your experience, what are the things that you would consider could be changed, removed, tightened up or improved to actually provide better outcomes and greater supply of supported accommodation in Queensland?

Ms Spruce: With regard to the data that we collect, because the RTA does not collect detailed demographic data for those living in supported accommodation, we can only gather from the anecdotal data that we hold when we collect a bond. We also do not receive copies of the tenancy agreement or the rooming accommodation agreement. Our view or position is probably limited as to what we can provide on this. However, like I said before, we also worked very closely through the stakeholder working group and the stakeholder forum with SAPA and other support organisations and refer information that we hear through that to the department and other services that may be able to provide better or more appropriate legislative change.

Mr MOLHOEK: My next question is to Mr Galer. You are there at the coalface.

CHAIR: Member, are you following on with the same line of questioning, or is this a new question?

Mr MOLHOEK: I am following on with the same line of questioning.

CHAIR: This will be your last question.

Mr MOLHOEK: Okay. The purpose of the inquiry is to look at reform, which essentially is to do with legislation and the allocation of government services. You are at the coalface; you are working with people. What are the things we need to do to improve access to supportive services? Do you see any barriers from a legislative point of view or a regulatory point of view that we could explore with the hope of actually improving supportive services in Queensland?

Mr Galer: I would not say that we necessarily see any barriers as such. Obviously the RTA is committed to providing education on rights and obligations to all parties with all tenancy agreements, including supported accommodation, and we do collect some data around that. Obviously we have, as Kristin has mentioned, some disputes that come through. We do look at trends across the sector and we provide that information to the Department of Housing to inform policy development.

Mr MOLHOEK: What are some of the trends that you are seeing in this supported accommodation space that the committee would find of interest?

Mr Galer: I am not sure we have any particular information. We have a very small amount of data, as Kristin has mentioned, with the number of calls that we receive and disputes. That is a very important section of the rental community. Obviously, as any issues arise, we will communicate them, but I do not think we can speak to that.

Ms PUGH: If a resident is evicted by a residential support provider, whether that be at short notice for a serious breach or after a process, are you notified immediately about that? What support exists if that situation should occur?

Ms Spruce: The RTA is not alerted to this immediately. The situation where we would get involved is either if we get a call from the resident or potentially a support organisation like QSTARS or if a dispute is lodged with the RTA. We have a triage system where any urgent matters are triaged appropriately, and we would get involved through the dispute resolution process and support both sides and provide information about the legislation and the rights and responsibilities.

Mr BENNETT: I am just curious about the role of the RTA in building standards compliance. Has that become part of the work that you do on the ground? You mentioned some regulatory reform for 2024; is that correct? Without putting words in your mouth, was that in your briefing?

Ms Spruce: In relation to minimum housing standards?

Mr BENNETT: Yes.

Ms Spruce: Yes.

Mr BENNETT: Do you monitor and audit that as well?

Ms Spruce: We do. We administer the Residential Tenancies and Rooming Accommodation Act and the newly implemented information and legislation around minimum housing standards which came into play for new and renewing tenancies 1 September 2023 and for all tenancies in 2024. In relation to that we do monitor complaints that come in, investigation requests. We also monitor all repair orders that are made by the Queensland Civil and Administrative Tribunal.

Mr SKELTON: The protections offered in rooming accommodation agreements are weaker than those in general tenancy agreements—for example, as mentioned before, it is quicker and easier to evict a resident. What are the reasons for this, and is there a way we could potentially change that?

Ms Spruce: As mentioned before, the RTA is an impartial statutory body that administers the legislation. I can refer to what supported accommodation is covered under the RTA Act and also options to opt into tenancy agreements. What might also be relevant are the potential reasons

rooming accommodation may be more suitable for residents in place compared to a tenancy agreement, which we see at times. There is an opportunity to opt into a tenancy agreement if required. Like I mentioned before, generally the rights and responsibilities are very similar for rooming accommodation residents compared to tenants. There is also the ability to terminate a lease or rooming accommodation agreement by both parties, like you mentioned before, in an easier way than for tenancy agreements.

In relation to the tenure or length of tenancy agreements and rooming accommodation agreements that I mentioned before, general tenancy median length is 18 months compared to supported accommodation, 8.9 months. They are generally shorter in length, as these types of agreements often suit the resident's needs.

Mr MOLHOEK: Can you outline the fundamental differences between a normal tenancy agreement and a rooming agreement just for the public record and for my better understanding of those issues?

Ms Spruce: Rooming accommodation is an agreement between a resident and a provider for a room or a number of rooms only with some facilities shared with other residents—for example, that is usually the kitchen and bathroom. In comparison, a residential tenancies agreement is an agreement between a tenant and a property owner or manager where the tenant generally has exclusive possession and use of the rental premises and does not share any facilities.

Mr MOLHOEK: If someone is renting out a private room in a residence, are they by definition under the legislation then deemed to be the provider?

Ms Spruce: Potentially. There are some requirements for it to be covered under our act. Usually it has to be three or more rooms that are rented out. The provider cannot live onsite either.

Ms PUGH: I just want to pick up on what I think was the close of your comment to the member for Nicklin and make sure I heard correctly. At the close of that response I think you said that the shorter lease time suited the needs of the specific kinds of leaseholders we are dealing with here. Do you want to elaborate on some of the reasons that could be in your experience?

Ms Spruce: Thank you. Yes, I did say that generally rooming accommodation agreements are shorter as these types of agreements suit the resident's needs. Because the RTA only collects anecdotal data, it is difficult for us to comment on potential reasons so we would have to speculate. Potentially, this may be because the resident has signed a shorter agreement or potentially the needs have changed for the resident as well and they maybe require different types of accommodation subsequently to the short rooming accommodation agreement they hold.

Mr BENNETT: Going back to minimum housing standards, I understand that rooming accommodation was meant to be compliant as of September 2023 and all other tenancies by 2024. Do we have any idea how many level 3, level 2 and level 1 providers are currently still not compliant with minimum housing standards?

Ms Spruce: As you said, minimum housing standards apply to all new tenancies and also recurring tenancies from 1 September 2023, with all existing tenancies starting in September 2024. We currently do not hold any data in relation to supported accommodation. We do monitor repair orders through the Queensland Civil and Administrative Tribunal. There have been a number of them, but nothing in relation to supported accommodation and tenancy agreements.

Mr BENNETT: Am I misreading rooming accommodation not applying to assisted living?

Ms Spruce: Rooming accommodation is generally the type of agreement that supported accommodation would utilise, and minimum housing standards do apply to rooming accommodation.

Mr BENNETT: Then if I can just re-ask the question: do we know how many of those assisted accommodation providers do not currently meet the 1 September 2023 minimum housing standard requirements? Is that a fair question?

Ms Spruce: The RTA does not hold that kind of data. We do not monitor compliance with minimum housing standards. The RTA has an offence provision under the RTA Act in relation to noncompliance with repair orders once it has been established that minimum housing standards have not been met.

Mr BENNETT: If I can just clarify, Chair. I thought that when I spoke to you earlier I asked about the role you would play on the ground in relation to inspections and compliance with certain building standards. I am not trying to verbal you or put words in your mouth, but I think that is where I was going. I understood there was a role for the RTA to look at compliance with standards of accommodation. Have I missed something? Are minimum housing standards not part of the remit of the RTA?

Ms Spruce: Minimum housing standards are part of the RTRA Act; however, the compliance function under the RTA is in relation to compliance with repair orders subsequently to—

Mr BENNETT: Repair orders. Thank you, Chair.

Mr SKELTON: We drilled down that leases are not as long for supported accommodation. Bearing in mind our experience, could a reason for that be that in a lot of instances people start in supported accommodation and then are moved into social housing situations? Is that a reason that would happen?

Ms Spruce: Potentially. One of the reasons could be that they move from one type of supported agreement to a different type of supported agreement. The RTA would only hold data in relation to that if a bond was held and provided to the RTA throughout the move between different supported accommodation. We do not collect detailed demographic data for those living in supported accommodation.

Mr SKELTON: By way of example, in my electorate I have had seven people supported by the Hub, which is supported accommodation, now moving to social housing. Would the Department of Housing potentially be somewhere we could get that information?

Ms Spruce: It would be hard for me to answer that question. We certainly do not collect that data, so I would defer to the Department of Housing.

Mr BENNETT: I am curious about the RTA's role if there were evictions brought to your attention. Do you do anything on behalf of clients who are evicted to try and find housing or accommodation solutions?

Ms Spruce: If we do get involved with a termination or notice to leave in relation to rooming accommodation, I mentioned before that usually that would come to our attention either through a call to our call centre or the dispute resolution service. A conciliator usually would get involved with that and interact with both parties to ascertain and support whether the rights and responsibilities have been met by all parties and then provide support to the resident usually and provide assisting services, QSTARS, or other supported accommodation providers that may be able to assist. We are the conduit between the resident and supported accommodation providers and services. At times we may have to call the police as well if a warrant of possession is provided, but generally that is our role.

CHAIR: I think we are almost out of time. On behalf of the committee, I thank you immensely for the work that it takes to do a submission and the time you have spent with us out of your very busy schedule. Your submission has contributed immensely to our inquiry. We thank you and we wish you a good day. Ladies and gentlemen, the committee will now take a short break and we will resume at 11.45 am.

Proceedings suspended from 11.27 am to 11.45 am.

CHAIR: Welcome back to our public hearing into supported accommodation. At the outset, I will turn to the member for Southport who has a declaration of interest and then I will follow.

Mr MOLHOEK: Thank you, Chair. I should declare that I am a director of Common Ground Gold Coast and have had a long, percolating interest in supported accommodation. It is on my public register of interests anyway, but I think it is important to express that in this forum.

CHAIR: Thank you, member for Southport. For the sake of transparency and integrity, I want to share that I am related to the Chair of SAPA, Mrs Yvonne Orley.

JOHNSON, Mr Nathan, Vice Chair, Supported Accommodation Providers Association

ORLEY, Mrs Yvonne, Chair, Supported Accommodation Providers Association

SHERLOCK, Mrs Tanya, Committee member, Supported Accommodation Providers Association

CHAIR: I now welcome representatives from the Supported Accommodation Providers Association or SAPA. I acknowledge each of you for being here today. The committee appreciates all the work that you do in the sector of residential and supported accommodation. We very much look forward to hearing from you, we look forward to talking with you and asking some questions, and we certainly benefit immensely from your submission. I understand Mr Nathan Johnson will be giving a brief opening statement. Then I will hand to our very capable deputy chair for his first set of questions. Over to you, Mr Johnson.

Mr Johnson: Thank you very much, Chair. I will pass over to Yvonne to do a welcome to country.

Mrs Orley: SAPA would like to acknowledge the Turrbal and Yagara people, the custodians of the land on which we meet, their elders past, present and emerging. We also acknowledge the First Nations residents we have in our care and acknowledge their specific cultural needs.

CHAIR: Thank you, Mrs Orley. The committee did, at the outset, begin with an acknowledgement of country, but I also acknowledge any First Nations people in the room. Over to you, Mr Johnson.

Mr Johnson: Good morning, honourable members of the committee, esteemed guests, fellow witnesses and colleagues here today. Ladies and gentlemen, today we are faced with an urgent call for change within the supported accommodation sector. The industry's viability hangs in the balance and the need for immediate reform is pressing. As representatives of SAPA, it is our responsibility to address these critical challenges with you head-on. Our industry is tasked with caring for some of the most vulnerable in our community. It is faced with unprecedented strains. The complexity of those being referred to us is increasing by the day. We face spiralling costs, no government funding and regulatory complexities which I think has been demonstrated by some of the earlier witnesses today. Together, this threatens our viability and the safety and security of our residents and our workforce.

Imagine, if you will, the complex lives of some of those in our care. They confront myriad adversities from mental health conditions, disabilities and discrimination, navigating a world that fails to understand their need. When they are unfunded and unsupported, these challenges reverberate through our facilities, risking the safety of co-residents and put excessive strain on our staff. Our providers simply do not have the option to knock off at 5 pm, or hang up the phone because a resident's behaviour breaches our workplace policy. For many individuals with challenging behaviours, we are their place of last resort. All of my colleagues here today can give you story after story of clients being abandoned by the system, dumped at our door with no supports, discharged in the middle of the night with no transport. There is rarely any follow-up to any new resident to our industry. Providers are expected to pick up the pieces and work through complex needs.

I will pause here for a moment. SAPA welcomes some follow-up questions from the committee around some of the earlier lines of discussion today. We have some points to address in that and also some of that is covered in our submission already.

We are at a crossroads where the status quo is no longer sustainable. However, SAPA stands here today not only to highlight the problems but also to propose constructive, actionable solutions. With the right support from government, we firmly believe that we can create a better tomorrow, a future where the quality of life of our residents is significantly improved and the burden on government resources is lessened. Our proposals aim at enhancing the care and support we provide while reducing the overall cost to the taxpayer.

We advocate for immediate funding to support the viability of the sector and elevate service delivery standards. This includes immediate funding to support increased levels of staffing, training and capital upgrades. Moreover, our proposal for two improved models of care, including the introduction of level 4 facilities, can help bridge the gap between clinical settings and supported accommodation. This would not only facilitate earlier hospital discharge but also serve as a preventative measure to keep those facing declining mental health out of hospitals. SAPA is committed to a holistic approach, focusing on integrated care models that break the cycle of disadvantage and homelessness. By investing in these solutions, we aim to significantly reduce the strain on mainstream government services and ultimately provide a higher quality of care for our residents.

In conclusion, SAPA urges the Queensland government to recognise the urgency of the situation and to work hand in hand with us to implement essential reforms. With the right government support, we can navigate these challenges, strengthen the industry and, most importantly, improve the lives of those who rely on our care. Thank you.

Mr BENNETT: I was interested, Nathan, to hear that you are going to address some of the lines of questioning this morning, and I did not hear that from you then, but I guess there will be an opportunity during our time together. I have spoken about the level of training required and I think we have established what that is about. I tried to prosecute the minimum housing standards, and I understand there is a regulatory unit now within the Department of Housing where, I think we have heard, there are five officers for the state. We have heard about the challenges of other issues this morning. It would be great to hear from the sector, though, if you could address those things particularly around the service unit within the Department of Housing and their role in accreditation and inspections. I am trying to come back to the minimum housing standards. Could you make any observations on how that impacts on the sector?

Mr Johnson: Yes, I think there are a few comments we could make about that. Firstly, I want to acknowledge the residential services unit. We do work constructively with them. They are a good team of diligent professional operators. However, I could say that they are under-resourced in comparison to regulators in other sectors. I have backgrounds in other regulated sectors, and it is a very different type of regulatory arrangement that we have as a supported accommodation provider to that of other sectors. It is typically on a reactionary basis due to complaints. It is typically on a three-year accreditation cycle, but most providers do not have regular ongoing interaction with the regulator. I would comment that, over the last two years, they have significantly made inroads into improving their communication into the sector, but I think there is a long way to go to providing ongoing training and support, and a regulatory approach that is not compliance driven. It is seen too much by our providers and our members as compliance driven, so therefore they do not want to engage because they fear any time someone walks in the door, they are just going to get a stick whacked over them or something. It is not a two-way conversation.

Mr BENNETT: I was going to ask you to give us an idea of what the unit might do. However, I guess that is a question for the department at some stage, Chair, and I will go down that path then. Can you address that training question I had about the staff and possibly what is needed within these facilities?

Mr Johnson: Yes, there are a few points there to underlay. I think definitely we can improve by staffing. Tanya, my colleague here, is very well-placed to answer that question, but I would first say, before I hand over to Tanya, that the stipulated regulatory training requirements within a level 3 is higher than within the NDIS. There are multiple lines of compulsory training that our staff must do which is significantly higher than any NDIS support worker. I will pass over to Tanya.

Mrs Sherlock: In regards to mandatory requirements, typically a Certificate III Individual Support would be in line with the type of support that we offer to our clients. It is not mandatory to have Certificate III Individual Support; however, a lot of us providers assist our staff members to achieve that. However, we do have mandatory requirements around first aid and mandatory training around fire compliance and medication compliance. There is a HLTHPS006 compliance for medication assistance. Under NDIS, there is no compliance required for medication support. You just have to demonstrate how someone is trained, but there is no actual compliance, whereas under residential services it is required. In regards to food safety, there has just been a regulation change to say that we need to comply with Standard 3.2.2A, which is a minimum of two food safety supervisors, plus a food handler. All lifestyle support workers or carers have to maintain the food handler component of that.

Mrs Orley: There is the training that we have to do for fire safety evacuation measures.

Mrs Sherlock: Yes. That pretty much is it.

Mr BENNETT: To follow up, I do not like ratios, but do you see a need, given the complexity of needs of your clients, for some sort of minimum ratio for staff-to-client contact?

Mr Johnson: It is a very vexed question and I am reluctant to answer that with a specific answer because it is due to funding for the sector. We can only provide support commensurate to the income that we can derive which is based off rents.

Mr BENNETT: Every centre would be different, I guess.

Mr Johnson: Every centre is different. There is no current regulated staffing ratio requirements, nor is there a regulation around 24/7 onsite coverage. Some facilities will not have staff overnight, for example, and so forth, but many providers do provide 24/7 coverage.

Mr SKELTON: You mentioned having a bit more assistance from the state government. Listening to the conversation so far, there does not seem to be a lot of interoperability with the Department of Health when you talk about people coming from hospitals into your service and also with regards to the accreditations that you have to have and the compliance and the money around that. Would that be something that the state could consider with TAFE partnerships and so forth to ease the costs to the providers?

Mr Johnson: Specific training, yes, we would greatly always assist and we would always promote staff increasing their levels of training and compliance. To pick up on your point about hospital interaction, our providers, generally speaking, depending on their location and their typical resident cohort, will interact quite closely with hospitals. Queensland Health is a behemoth of an organisation, very diverse, and every region is run differently with different roles covering hours. There is no consistent way for our sector to engage with each health district, but many providers work as closely as they can with Queensland Health and particularly with discharge coordinators, mental health nurses, community care mental health nurses. They will work very closely with complex care coordinators and nurse navigators. However, it is not on a strategic level; it is at the ground level. To advocate for our residents, the community mental health program—which a number of our residents across the state are either in or in need of being in—is, from our perspective at least, dramatically overstretched, very reactionary and unable to provide the mental health support that our residents require when they require it.

Mr MOLHOEK: I would like to ask a few questions about SAPA and how it is structured, how it is financed, how many members do you have—

CHAIR: Member, for Southport, you can ask one question and then we can come back to you.

Mr Johnson: I am happy to give a broad definition.

Mr MOLHOEK: Describe the broader structural issues of SAPA. Who are you?

Mr Johnson: SAPA is a provider-, volunteer-run organisation. All members of SAPA are providers themselves. We all are providers ourselves. It is self-funded by member contributions. We pay a fee per allocated bed until very recently when we got our very first direct government funding to provide for one part-time or short-time project officer. Apart from that, SAPA is completely volunteer-run by providers.

Mr MOLHOEK: Approximately how many members would you have in Queensland?

Mr Johnson: I think we have 16 members and we cover about 700 to 650 total bed capacity. I can come back to you with those exact details if you prefer.

Ms PUGH: My question follows on a little from the member for Nicklin's. I note in your submission the big challenges you face around primary health care. You noted that one GP closing meant there were a number of facilities that no longer have primary care. Do you see a role for the newly opening satellite hospitals, especially in the south-east corner, around providing primary care?

Mr Johnson: We have engaged with Queensland Health on that very matter. Currently it sits outside of our scope. We would have to transport our residents to those facilities, which is something we do not have capacity or funding for, and it would be reliant on the residents to make their own way to those facilities. That is a bridge too far for many residents and something they are unable to do regularly.

Ms PUGH: The GP would come to the house, would they?

Mr Johnson: Yes. Most providers have a GP who comes in-house, runs a clinic for as long as they need to through the course of a day or on a regular recurring basis in a dedicated room. This provides primary health care for residents in an environment where they are able to engage.

Mr BENNETT: We are hearing about the complexity of some of your clients. If there was a need for more tailored specialist services to be engaged for your clients, are there any of those specialist services that you see would be greatly advantageous to the service providers you represent?

Mr Johnson: That is a very long question with answers we could be here all day for. I will try to keep my answer brief. We were advocating for direct funding to provide us to increase levels of service within the facilities to keep residents better catered for within facilities. We will work with any external agency, and our providers do work with any external agency that comes in to provide supports to residents directly. There is a whole section in our submission—and I would ask you to read through that—on the mental health system. We are just a very small part of that system. Improving that system is a complex and expensive proposition. From our direct perspective, increased funding to provide higher levels and higher trained staff onsite is something we would greatly appreciate.

Ms Sherlock: Before the NDIS the Queensland government funded a program called the Resident Support Program. That provided funding to NGOs that were not affiliated with providers onsite. They would come in and provide shower support and a very limited number of group activities to clients in the community. Whilst it helped with viability to some point, it did not work on a lot of levels. I will give you an example. They come in and provide shower support to our guys. Then they need to go to the hospital, so someone goes on the waiting list in the hospital system. They are sometimes on the waiting list for six, eight or 12 months to get seen by the hospital system. We have an external agency coming in to support that person to go to the hospital to meet their appointment. The doctor turns to the client and says, 'So what are you here for today, young fella?' The young fella says, 'I don't know.' Then the other support provider goes, 'I don't know because I don't know the person.' That person gets sent home because we are no longer in the loop. Then they have to re-enter the waiting list again. Their health needs are being neglected, basically. This is what happened prior to the NDIS.

This is why we are advocating for funding within the service itself. We are with the residents day in, day out. We understand their little quirks. We understand what their triggers are. We understand that if we park there, that is going to trigger. That colour blue sitting over there is going to trigger this resident, so I am going to find another spot where I know that person is not going to be triggered. If a doctor speaks to the client and says, 'What's your disability?', that might trigger them because they do not want to talk about their disability. We pretty much basically live with the guys. We know everything about them. We know their medications. We know their health matters. We know that sort of thing. We feel it needs to come from internally. In order for them to get continuity of care and for things to be sorted out, to stop ringing the Queensland Ambulance Service or the police and then going in through the hospital accident and emergency all the time, if we were there to support them through that it would stop a lot of that.

CHAIR: Mr Johnson, are you aware of the number of clients or individuals who occupy public hospital beds who are waiting on residential accommodation? What is the process from lengthy public hospital stay or hospital stay into supported accommodation?

Mr Johnson: I could not give you those figures. Queensland Health has recently announced those under the Long-Stay Rapid Response Plan and the committee can get those figures publicly. There is a detailed process for referral into most facilities. Most facilities will have a referral process. SAPA provides a template for members to take down histories of behaviours, mental health, addictions and so forth. They will then make a risk-based assessment on what is on paper. They will then typically ask for that person to come in to do a meet and greet. They come to the site, they will visit, they will see the site. They might show them their prospective room, interact, see how they interact with other residents, and then they would go back to hospital and then a transition would be arranged after that. That would be a typical process.

The Long-Stay Rapid Response Plan that has been put in place is typically for people who are far too complex to come into a level 3 facility. They require one-to-one, 24/7, active overnight support which is unable to be met in the current level 3 environment.

Mr BENNETT: Earlier we heard conversations about fees and charges, and the Public Advocate and the Public Trustee commented. Is it your opinion that when the RTA signs a rooming agreement there is transparency for clients about fees and charges and that on behalf of their families this is transparent and up-front?

Mr Johnson: All fees are in the RTA in the R18 agreement. All fees are in that agreement, and it is there. The breakdown between the types of fees, be it accommodation, food and support, probably could be improved. Providers as a rule do not see it on an individualised basis because they

are looking at a facility from a whole level. If there is $50 or $100 put down for support—there are different models of care here, so I cannot speak for everyone in the industry—many providers will look at it on an holistic basis because it is a safeguarding issue from their perspective. They have staff on 24/7 who provide care in the event of an emergency or ad hoc. If, for example, a resident had that personal care service removed, do the staff onsite not provide care for that person in an emergency, or if they soiled themselves, or they are in need of a shower or otherwise? From their perspective, it is a safeguard issue. They are paying $390,000 per year for 24/7 staff coverage. That is the cost for one staff member to be onsite around the clock. It takes a team of about four or five people. That is the cost of that. From a provider perspective, to chip at this little bit you cannot provide that care. It is an holistic approach to providing that.

Mr BENNETT: The Public Trustee commented about the difference in agreements they saw. Some had one lump sum, some might have three or four different components to it. They are advocating on behalf of that person's capacity to make those decisions, so it seems to me that is something that should be tidied up.

Mr Johnson: We would welcome that. There are different models within the industry. There are other providers who will provide only a level 1 service within a level 3, and then they would look to NDIS or other services to cover that.

Mr BENNETT: If you itemise every single service or expected service they are going to receive, how does that affect that 24-hour example?

Mr Johnson: The industry's viability is in question. If you took 10 per cent off the revenue, they would not be able to provide the staff. They would have to withdraw staff, and they would be withdrawing staff to all residents, not just that one resident. It is a safety issue.

Mr BENNETT: For example, I am signing a rooming agreement that says out of my $800 a fortnight, $100 will go to food, $100 will go to accommodation and the rest will go into service care. Where is the 10 per cent reduction?

Mr Johnson: If you took out the care component. What the Public Trustee would typically do is they would look at the rental component, which might be $500 or $600, then they would see the food component and then they would see the care component. Then they would typically come back and say, 'This person has an NDIS care plan. We want to get our provider to cater to that care plan, so we would like to take the care side off of that.' From a residential perspective they are saying, 'My staff are here regardless. The NDIS staff are on scheduled services. They are not here after-hours. They are not here in emergencies. My staff is here, so you cannot take that away.'

Mr BENNETT: I get it now.

Ms Sherlock: So again if someone soils themselves after just receiving an NDIS service from somebody and they have driven out the gate, who helps that person? They are not there. That is why we are saying if it was all in-house, there is someone there all the time.

Mrs Orley: I think people from the outside looking at us think about our fees and charges being commiserate with mainstream. Of course our fees and charges cover the complexity of needs of our clients. We meet the gap between other organisations because we have a 24-hour duty of care to our residents. We are looking to have appropriate funding to meet that. You are speaking about social needs, you are speaking about health needs. These people sometimes come to us and they have been badly neglected, and it is up to us to spend a lot of time getting them back up to scratch to be able to function well. There is a lot of unseen work that we do.

I think that also, speaking to Mr Bennett, our clients have a disability. They will always have that disability. You can do as much as you can to enhance their skills et cetera. They also have escalations. This person with schizophrenia may be okay today and not need as much care, but tomorrow they may be really having a problem. One of the other benefits of them being in supported accommodation is that we know them. We know when they have been triggered, when they are not themselves. We can pick up on that. The value in that is preventive and it helps a lot of them not to be in the hospital system. The hospital system has a real problem with dealing with our clients. During COVID they could not manage the behaviour of our clients in their care. They often try to discharge early, and then we are still left to manage someone who is quite ill.

CHAIR: Mrs Orley, I think that every single example you provided helps the committee understand the complexity of the situation and the diversity of needs and it is really helpful, so thank you.

Mr SKELTON: My question is to you, Mrs Sherlock. When the Public Trustee was up before we were talking about having regulatory reform, obviously transparency around finances and things like that. What we are very cognisant of is that you are providing a 24/7 service. Can you give me any insights into the idea of a more social-centric model and ways of funding to achieve that so there is interoperability?

Mrs Sherlock: A lot of us are also NDIS providers so I will provide a little bit of information around that as well. As that is individualised support—and this is only a rough number—approximately 75 per cent of clients have an NDIS plan. They are able to go out into the community and do what ordinary people do in everyday life. However, there is a cohort of around 25 per cent—and that is only a rough estimate—of people who get nothing. They are sitting with residents in the same facility saying, 'Well, how come Johnny is going out and getting this support and I can't get to go? I want to go shopping and I want to do this.' It is a very inequitable system and it is unfair. We do not have the answers for them. At the moment, as much as would love to do it, there is no money to be able to provide that individualised support to residents.

When the NDIS was introduced it made a very big difference to our residents. It gave them opportunities that they could never even dream of. There have been so many success stories about people who moved to live their lives the way they want to. There are others who have rebounded back. There are people who have gone from living in communal settings such as ours into SIL or SDA properties—with all that funding—and have come back because they have missed that sense of community amongst their peers and their friends. In a SIL house they felt a bit like a goldfish in a goldfish bowl because they had staff overlooking them 24/7. Whereas, in facilities such as ours, they can wander around and do what they need to do it. They do not have staff constantly overlooking, but there is a staff member around if they need it. It works really well for most of the cohort of people we have.

To be honest, when NDIS came in, I sat there and thought, 'Oh my God, maybe no-one wants to live with us anymore?' Then we had meetings with our clients and every single one, bar one, said, 'I want to stay; I just want more services.' That was our cohort. I know that most of them are the same. They have their friends. They have their community already established. They just need extra supports to do what their NDIS counterpart can do. Aged-care funding is appalling. A level 1 package is $9,000 a year. It is not even a 15-minute shower a day. For you and me, we get to have a shower every day. Our residents do not even get to have a 15-minute shower. If they are on an aged-care package to start with, their clinical needs say that they require support. You are pushing an old person into have a shower within 15 minutes. It does not even make sense. Even our aged-care clients struggle compared to the NDIS cohort of clients that we house.

CHAIR: Thank you. Another important addition is when we add age onto the complexity of needs.

Mr BENNETT: We were talking before about issues concerning some of the clients and their obligations with specialist services—that is, a trip to the doctor or hospital. Would there be a role for client advocates we have met in terms of keeping residents calm? They would understand the advocate and would have a relationship with the advocate.

Mrs Orley: I am very different from the other supported accommodation providers. I am a smaller provider and I am also a registered nurse. I have funded 20 hours of health care coordination a week, but that is because of my background. I would like to see nursing assessment and an RN available onsite for all of our supported accommodation people. Due to their complex needs, our people are on a high level of medication and have a lot of side effects and symptoms from that medication. Even with today's weather, we have to keep monitoring our clients because they dehydrate very quickly and do not like having a drink of water. We have to put things in place. We have to set our environment to support the needs of our people. I note the member is having a drink of water.

Mr BENNETT: You reminded me!

Mrs Orley: We purposely give out medication at meal times and we put big glasses of water on the table for the residents. Our residents have diabetes, kidney problems et cetera, and health is a big aspect of this. As Nathan said, there are psychosocial needs. We need mental health clinical staff. It would even be good if there were vocational placements onsite so that we get that additional support. A lot of our staff have training in mental health, behavioural management et cetera, but the healthcare needs of our residents are an important issue. As an aside, I have lost two residents who moved from my facility to other facilities because they were not aware of the issue of hydration and bowel problems. One died in their 30s and one died in their 40s. These are really important issues. Our cohort of people age earlier than others.

Madam Chair raised the issue of the aged. There is no facility available for disability aged. When I have to move people to aged care, they are still young in their mind. They are not an old person. They will be 16, 20 or whatever forever. They still want to do those things and are not able to relate to the older people who are there.

CHAIR: That is further interesting information. It certainly highlights the further complexity.

Ms PUGH: I note that your submission actually goes into quite a bit of detail around the health pieces on which you have just elaborated. I should say for the record, Chair, that I have met Mrs Orley in a social capacity. You refer a couple of times and in a couple of different ways in your submission to ambulance call-outs. Can you elaborate on opportunities that you see to reduce the number of ambulance call-outs for all of the different reasons that happen, whether it is for an emergency or for transport purposes?

Mr Johnson: Yes. It is an unfortunate that an ambulance is often the provider's only recourse when someone is having health issues. Early intervention, particularly when a resident's mental health is declining, is something that is, frankly, non-existent within the space. Within our facilities we have a number of residents on mental health plans with community mental health run by Queensland Health. They have a case manager in that respect. They will come out to see them and make their regular appointments and so on. When we call them up and say, 'Such and such has slid into psychosis. We can see their behaviours changing and so on' they will say, 'I'm too busy. I can't come out; maybe next week.' We can usually see it days ahead of time. They were slowly sliding into psychosis, causing more and more issues onsite, causing more dramas, safety issues for co-residents, safety issues for our staff. We will call the mental health worker and they will just not come. Eventually, we are usually told to call an ambulance. By the time we call the ambulance, the ambulance will stop in the driveway, not enter the facility and be stuck in our driveway for several hours because they are waiting for police assistance. They will not attend and will not treat someone in psychosis without police attendance. We can have an ambulance in our driveway for three, four or five hours because the police are busy. That is tying up an ambulance.

They might take that person to hospital, but then they are stuck on a ramp for five hours. They go through that. They finally get into the emergency ward. They then ask that resident at the emergency ward, 'Why are you here?' and they 'I don't know.' They are taken home; they are not assessed, not anything. They come back that night and tear the place apart. We call the ambulance the next day and the cycle repeats. It just goes on and on because the emergency services will not admit them into the hospital because of their psychosis. The mental health case workers in the community are overstretched and cannot help them. I do feel very sorry for the ambulance. They are on the front line trying to deal with someone who is delusional and in psychosis. They are unable to handle them. Then the resident gets dumped back at our facility time and time again.

Mrs Sherlock: Then you have other residents in the facility coming to you saying, 'I'm scared, because that person is going to hurt me. I don't know what to do.' It is not just one other resident; it is multiple other residents. In terms of the question about the RTA agreements—because it is such a reactive system—being able to evict somebody straight away to the hospital or the health system means it is seen as an emergency because this person no longer has a home so 'Let's gets support for them.' However, they are back in hospital again taking up a bed because there is no other way around it.

Mr Johnson: Evicting into hospital is an unfortunate strategy that has to be used in an emergency. We do not use it very often, but we have to evict into hospital care as it is the only way to have them admitted.

Mrs Sherlock: Safely.

Mr Johnson: Safely, otherwise they are bounced out onto the street.

CHAIR: Following on from that, is the number of spaces or availability of mental health units restrictive as well?

Mr Johnson: I am not familiar with the inner workings of the hospital system, but they are at capacity.

Mrs Sherlock: They usually will not take them straight into the mental health unit. They have to be able to be assessed in A&E first.

Mr BENNETT: I understand that SAPA does not represent all providers?

Mr Johnson: That is correct.

Mr BENNETT: How do we engage with those other providers because obviously we need to do all we can to make this work?

Mr Johnson: We have been communicating to all registered email addresses. We have received some correspondence and some feedback from non-SAPA members. We have been sending out communication to all registered providers, levels 1, 2 and 3. We have received some communication back, but we have not been able to meet with them in person.

Mr BENNETT: Roughly, what are the numbers that we are still trying to bring into the fold?

Mr Johnson: There are now 43 level 3s. There is a declining number of level 3s in the state. We are in communication with about half of them and that is about three-quarters of the number of registered beds.

Mrs Sherlock: We would like to include level 1 and 2, which would bring that up to 250 to 275. It all comes down to cost. No-one can afford the fees. No-one can afford the time because they are too busy cooking a meal, showering somebody or whatever to attend meetings. There is no money. I am so glad this inquiry has come about, because I am actually third generation in this business. My grandmother started it as the first in the state. I grew up with residents onsite. I ate the food they ate. I shared the showers and the bathrooms that they used. We still do. I do not live onsite now, but we do that. We are a community. We are a family. We want to make sure that the residents are looked after. You cannot even compare us to funded NDIS and aged care. People will knock our industry, but a lot of providers have met the accreditation requirements for NDIS—and some under aged care—and surpassed them. I know from our audit that the auditor, who is a national auditor, said, 'You guys are in the top five per cent of Australia.' We have the knowledge and the experience. We can do this, but we need funds to be able to make it work for our residents. We know what we need; we just need the support and the backing of the government.

Mr BENNETT: Well said.

CHAIR: Thank you, Mrs Sherlock. This has highlighted for me this morning just how resource intensive the sector is, with the reason being the complexity of the individuals and certainly the diversity of their needs. Age is one issue. Mental illness, psychoses et cetera add to all of that. We thank you immensely for your time this morning. I think the committee certainly has benefited from all of the contributions and has a much greater understanding of the sector. We still have a lot more to learn, but certainly you have been incredibly helpful. We thank you for taking the time out of your very busy schedule. We have one question on notice—data regarding the number of registered beds. Are you okay with that, Mr Johnson? Could we have the answer by 20 December and if you cannot please let me know. I thank everyone for their time today. I cannot even say, 'Have a good weekend' because it is Wednesday, but have a great rest of your day. Thank you again for your contribution. That concludes this hearing. I now declare our public hearing closed.

The committee adjourned at 12.30 pm.