Submission

No 33

STATUTORY REVIEW OF THE COMMUNITY SERVICES (COMPLAINTS, REVIEWS AND MONITORING) ACT 1993

Organisation: Department of Ageing, Disability and Home Care

Name: The Hon Kristina Keneally MP

Position: Minister for Ageing & Minister for Disability Services

Telephone: 9228 5188

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The Department of Ageing, Disability and Home Care

General Comments regarding the Statutory Review of the *Community Services (Complaints, Reviews and Monitoring) Act* 1993.

- It has been recommended that (g) be clarified as follows:
  To provide for independent monitoring of community services and programs, both generally and in particular cases (professional clinical advice is to be sought where appropriate).

- It is recommended that additions are included to point (f) as follows: to encourage compliance with, and facilitate awareness and education of the objects, principles and provisions of the community welfare legislation. Education is a critical element in raising awareness of the role of legislation in guiding the community toward desired outcomes (e.g. equity, equality and social justice).

- Official Community Visitors - The Official Community Visitors Scheme continues to foster an environment where 'complaints and independent monitoring' are being promoted as positive approaches to improving service provision. This situation satisfies 1 (a) of the Objects of the Act and confirms its validity, and the appropriateness of the terms of the Act.

- The Ombudsman - Correspondence received from the Ombudsman throughout the year, detailing the complaints of service users or their advocates, provides DADHC with an opportunity to resolve those complaints and to review its own practices whenever this is appropriate. The Ombudsman's enquiries and the resulting response and review by DADHC, confirm the validity of the Objects of the Act under 2 (b) and the appropriateness of the terms of the Act.

- The Ombudsman's annual Report of Reviewable Disability Deaths in care - The Ombudsman's findings in the Report of Reviewable Disability Deaths in care every year are the result of an 'independent monitoring' process of the 'particular cases' that have resulted in client deaths. The work undertaken by the Ombudsman includes recommendations for DADHC to address issues coming out of the Report that allow DADHC to respond appropriately. The validity of the Objects of the Act under 2 (g) and appropriateness of the terms are upheld by this function.

- There is a clear role for the Ombudsman in providing an independent body to investigate, resolve and terminate complaints and also to provide education, advice and training to Non-Government Organisations.

- In regard to responsibility of the Ombudsman, this could be expanded to include providing reports for Departments that fund services on visits / investigations and concerns held by the Ombudsman regarding service providers.

- The terms of the Act require updating to reflect changes to the Department's structure and incorporation of Home Care into Department of Ageing, Disability and Home Care.

- Terms referring to 'Handicapped Persons' need to be updated in line with the NSW *Disability Services Act* 1993 and refer to 'a person with a disability'.

- Handling complaints, conducting reviews and monitoring are 3 different areas/ disciplines. The Act may benefit from distinguishing each of these areas in a separate manner to ensure a thorough response to the principles and objects of each.

- The principles and objects of this act appear to be more geared towards complaint handling. While the Act does contain some broad statements on monitoring and reviews, it has limited information on the objects and principles for reviews in particular and also on monitoring.

- The principles and objects include clauses that reflect a complainant's right to take issue with things that have directly affected them / their family member / person they are advocating for etc on a direct impact level only. There does not appear to be clauses that reflect an opportunity to feedback on high level policy and more general system-wide issues.