Chapter 3

Delivery of the 1800 RESPECT service

Introduction

3.1 The chapter addresses matters raised during the inquiry regarding the delivery of the 1800 RESPECT service, namely:

- criticism of the First Response model; and
- privacy, confidentiality and consent issues.

Criticism of the First Response model

3.2 As noted in Chapter 1, the DSS determined that in the 2104–15 financial year 72 per cent of calls to the 1800 Respect helpline went unanswered. As a result, on 16 August 2016, the operation model for the 1800 RESPECT service was changed to a 'First Response' model, which is managed by MHS.[1]

3.3 RDVSA strongly advocated its counselling model, where specialist trauma counsellors answer all calls, as a national evidence based best practice service.[2] RDVSA argued that the advantage of its triage service, which operated from April – August 2016, over the First Response model is that callers to the 1800 RESPECT service would continue to be answered by specialist trauma counsellors in keeping with the evidence of best practice.[3] In relation to the concept of a triage model, RDVSA stated that the research:

> [means] that a triage system while to some degree effective for other forms of medical conditions is contraindicated in the context of working with a survivor of domestic violence, childhood sexual abuse and abuse.
>
> The triage model offered by Medibank does not meet even the most basic requirements as per the evidence when working with trauma as a result of sexual assault, domestic or family violence.[4]

3.4 However, DSS's focus is on the role and purpose of the 1800 RESPECT service. DSS stated:

> Let us be very clear that the DSS funds MHS and MHS funds RDVSA for answering calls that come onto the line. This was the intent of the national plan in setting up the 1800RESPECT service. We already had trauma counselling services. We already had state based domestic violence

1 Department of Social Services, *Submission 31*, p. 34.

2 Rape and Domestic Violence Services Australia, *Submission 57,* p. 1.

3 Rape and Domestic Violence Services Australia, *Submission 57,* p. 32.

4 Rape and Domestic Violence Services Australia, *Submission 57,* p. 33.

> services. What 1800RESPECT was set up to be was a 24-hour service where women could get their calls answered when they made the calls.[5]

3.5 The introduction of the First Response model has attracted significant criticism across the not-for profit women's welfare organisations. Many organisations have advocated for RDVSA to continue to be funded as the sole provider of the 1800 RESPECT service based on its original counselling model.[6]

3.6 One critic of the First Response model called it 'an unmitigated disaster with deleterious impacts on clients'.[7] Another said:

> Medibank [MHS] have no idea what they are doing in this space. Their core business is insurance, not crisis support and intervention.[8]

The need for specialist trauma counsellors to answer all calls

3.7 Concern was expressed that women calling the 1800 Respect service are no longer telephoning to a qualified trauma counsellor, with the result that they have to 'tell their story twice' on referral by the first responder to a trauma counselling service.[9] It is argued that the approach not only takes away the first line of qualified contact, but also potentially delays the appropriate service provision.[10] The fear being expressed is that referral organisations will lose confidence in the 1800 RESPECT service, and cease to make referrals to the service.[11] Based on anecdotal reports of their clients being dissatisfied with their experience with the First Response 1800 RESPECT service, some organisations are tailoring their advice to ensure referral to a trauma counselling service, or removing the 1800 Respect telephone number from their referral brochures.[12]

3.8 Supporters of the RDVSA model expressed concern that the First Response model does not address the vulnerability and life situations of callers to the 1800 RESPECT service who are at greater risk of violence, mental health issues, and

---

5 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

6 See for example: Women's Health NSW, *Submission 32*, p. 2; Dr Ses Salmond, *Submission 30*, p. 2; Name withheld, *Submission 11*, p. 1; Name withheld, *Submission 12*, p. 6; Name withheld; *Submission 48*, p. 2; Mr Adrian Cooke, *Submission 52*, p. 1; Domestic Violence NSW, *Submission 46*, p. 5; Australian Council of Trade Unions, *Submission 38*, p. 1.

7 For example, see: Dr Ses Salmond, *Submission 30*, p. 2.

8 Name withheld, *Submission 54*, p. 1. See also: Name withheld, *Submission 48*, p. 2.

9 Name withheld, *Submission 11*, p. 1; Australian Women's Health Network, *Submission 2*, p. 3; Leichardt Women's Community Health Centre, *Submission 43*, p. 2.

10 Australian Women's Health Network, *Submission 2*, pp 2–3. See also: Ms Judith Shepherd-Pemell, *Submission 6*, p. 1; National Council of Women of South Australia, *Submission 9*, p. 2.

11 See for example: Australian Women's Health Network, *Submission 2*, p. 2; Name withheld, *Submission 12*, p. 3.

12 See for example: The Hunting Ground Australia Project, *Submission 3*, p. 5; Domestic Violence NSW, *Submission 46*, p. 4; Fair Agenda, *Submission 34*, p. 3; WILMA Women's Health Centre, *Submission 22*, p. 1; Family Planning NSW, *Submission 27*, p. 5.

violence who need to speak to a trauma specialist counsellor at the first point of contact:

> The triage model introduced in 2016 and provided by Medibank Services is problematic and not in line with best practice models. Callers in crisis don't always present as cohesive, knowing what they want. Only skilled counsellors can support a caller in crisis to assist them to 'gently work out what has happened' and what their needs are.[13]

3.9 Ms Natalie Lang, Branch Secretary, ASU, noted that when all calls were answered by a specialist trauma counsellor, 98 per cent of the callers required a counselling response, and with the First Response model, that figure is now 25 per cent:

> It is only by having specialist counsellors who can ask the right questions and develop that trust that people then disclose that they are the person experiencing trauma and can then receive the counselling they need….
>
> With the implementation of the triage model, it is a lower-level-qualified counsellor who is answering the call—they are not a specialist sexual assault and family violence trauma counsellor—and they are under pressure to answer lots of calls because answering lots of calls is very important. So, if a person calls and says, 'I'm looking for some information,' they will be told which website to go to and which fact sheet to read, or given a phone number to call at another time…
>
> It is inconceivable that overnight there was a drop from 98 per cent of people calling the service and needing a counselling response to just 25 per cent of people needing a counselling response.[14]

3.10 Dr Roslyn Baxter, Group Manager, Families Group, DSS, defended the introduction of the First Response model, highlighting the improvement in numbers of answered calls:

> KPMG identified…that adding a first response triage model would mean more women could get more help more quickly. This improvement was made on 16 August last year. Almost immediately, it led to a 172 per cent increase in the number of telephone and online contacts that were answered. It allowed an additional 40,500 people to receive support in the moment that they needed it and it dramatically decreased the length of average call wait times from 10 minutes to 37 seconds.[15]

---

13 Ms Marisol Pacheco, *Submission 55*, p. 1. See also: NSW Women's Alliance, *Submission 42;* p. 3; Blue Mountains Women's Health and Resource Centre, *Submission 37*, p. 1; Victorian Women's Trust, *Submission 33*, p. 3; Dr Ses Salmond, *Submission 30*, p. 2.

14 Ms Natalie Lang, Branch Secretary, Australian Services Union NSW & ACT, *Proof Hansard*, 8 November 2017, p. 6.

15 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

3.11 DSS and MHS addressed the claim that, prior to the introduction of the First Response model, 98 per cent of callers required a counselling response. Ms Nicole McMahon, General Manager, 1800 RESPECT, MHS, noted that the 98 per cent figure needed to be viewed in the context of the unanswered calls to the service:

> My comment to that would certainly be that the perspective that 98 per cent of the callers needed trauma specialist counselling is based on 33 per cent of the callers being able to get through. In that specific period there were 42,560 who tried to reach out and get help who were not able to get help. I can only give you the information based on what we have seen since we [MHS] have been running the service.[16]

3.12 In its submission, DSS highlighted that it was not possible to know what type of services were required by people who did not have their call answered. DSS noted that, prior to the introduction of the First Response model, the 1800 RESPECT service 'included no mechanism for determining whether callers waiting on the line were in imminent danger or immediate need'.[17]

3.13 Dr Baxter also questioned the rigor of the data collection upon which the 98 per cent figure was based:

> We also know that the way data was being collected by RDVSA at that time was not consistent and replicable. From the department's point of view, we are much more confident that we have robust, repeatable data now, and we are confident that 70 per cent of the calls that come into the service require other types of support, such as information and referrals. This is also consistent with the broader role that we play under the national plan where we know that the 1800 number is promoted for a range of purposes. We know that other services use the number to get information. We know that it's provided to schools—to school teachers who are for providing information—and to a range of other service providers, as well. We also know that it's provided to the media when they are seeking information about how to pitch a particular story or where they should go. So to us, also, the data we are now seeing seems a far more accurate representation of calls that are coming into the service.[18]

3.14 Ms Annette Gillespie, Chief Executive Officer, safe steps Family Violence Response Centre (safe steps), indicated that, in her experience a requirement that 98 per cent of callers needed trauma counselling 'sounds very high'. Ms Gillespie continued:

> I would think it's much more likely to be around 25 per cent that would need intensive trauma informed—not really even need, but be seeking. The

16 Ms Nicole McMahon, General Manager, 1800 Respect, Medibank, *Proof Hansard*, 8 November 2017, p. 22. See also Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

17 Department of Social Services, *Submission 31*, p. 6.

18 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

> majority of women are seeking anything from information to practical solutions and safety. Often, women calling are at a very contemplative stage of learning about family violence and making decisions about what they want to do with their relationship. To suggest that those women require a trauma informed response is, in fact, doing them a disservice.[19]

3.15 Dr Baxter noted the introduction of the First Response model provided a 'surge capacity to support those women who need to talk to a trauma specialist'.[20] Dr Baxter also addressed the criticism that callers would need to retell their story:

> …we have heard consistently the allegation that women will have to retell their stories. They will not. Warm transfer means that the first responder tells the story to the trauma specialist and the woman caller can hear the conversation.[21]

Qualifications and supervision of first responders

3.16 Another criticism of the First Response model concerned the qualification of the MHS counsellors compared to RDVSA's counsellors, with anecdotal evidence that MHS are employing unqualified staff who do not receive specialist training.[22] Examples were given of inadequate or inappropriate triage counselling by MHS first responders.[23] For example, Mrs Emily Lachevre, a RDVSA trauma specialist counsellor informed the committee:

> Like many of my colleagues, I have also taken a call from a MHS first response worker who turned off all the recording equipment on the phone and shared her concerns about the organisation being ill equipped to deal with the content of the calls that she and her colleagues had been receiving. She suggested that she had received just one day's training and had no prior experience working with traumatised people before she was allowed to triage calls for MHS.[24]

3.17 RDVSA stated that its counsellors must have a minimum of a four year degree in social work or psychology or equivalent, and at least three years counselling experience, adding that most RDVSA counsellors hold additional postgraduate

---

19 Ms Annette Gillespie, Chief Executive Officer, safe steps Family Violence Response Centre, *Proof Hansard*, 8 November 2017, p. 30.

20 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

21 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

22 See for example: Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 21.

23 See for example: Name withheld, *Submission 12*, pp. 1–6; EROC Australia, *Submission 15*, pp. 1–3; Victorian Women's Trust, *Submission 33*, p. 3.

24 Mrs Emily Lachever, Trauma Specialist Counsellor, Rape and Domestic Violence Services Australia, *Proof Hansard*, 8 November 2017, p. 10.

qualifications and have more than the minimum of three years' experience.[25] A psychologist with 30 years' psychology delivery experience states:

> Given my experience as a clinician, I can reassure you that the team of counsellors at RDVSA are the very best of clinicians I have ever worked with….
>
> Most staff have multiple / high level degrees, AND many years' experience AND specific long term experience … .[26]

3.18 Women's Domestic Violence Court Advocacy Service NSW (WDVCAS) supported the need for appropriately trained trauma specialists with tertiary qualifications in psychology, social work or counselling.[27] Ms Judith Shepherd-Pemell noted that generalist counsellors are not trained to deal with trauma.[28]

3.19 MHS advised the committee that all calls to the 1800 RESPECT service are answered by a counsellor with a three-year degree in a relevant field and a minimum of two years counselling experience.[29] Dr Baxter also addressed the argument that the MHS counsellors were unqualified:

> …we have seen damaging accusations that first responders are unqualified. This is wrong. We know, personally, that accusation has been very distressing for first responders. Everyone who calls 1800RESPECT will speak with a qualified counsellor and can get counselling, should they require it. These qualified counsellors have a minimum three-year tertiary degree in social work, social services, welfare studies and psychology, and a minimum of two years' full-time counselling experience.[30]

3.20 Dr Baxter noted the 'intensive training' that the first responder counsellors undergo before responding to calls, stating the training 'is very similar to that provided to the trauma specialist arm of the service'.[31]

Support for first responders

3.21 The committee received evidence covering a number of issues in relation to the support provided to the first responders employed by MHS.

---

25 Ms Karen Willis, Executive Officer, Rape and Domestic Violence Services Australia, *Proof Hansard*, 8 November 2017, p. 9; Rape and Domestic Violence Services Australia, *Submission 57*, p. 43.

26 Name withheld. *Submission 16*, p. 2.

27 Women's Domestic Violence Court Advocacy Service NSW, *Submission 17*, p. 3.

28 Ms Judith Shepherd-Pemmell, Forensic Psychotherapist, *Submission 6*, p. 1.

29 Ms Justine Cain, Divisional General Manager, Medibank Health, Medibank, *Proof Hansard*, 8 November 2017, p. 16; and Ms Nicole McMahon, General Manager, 1800 RESPECT, Medibank, *Proof Hansard*, 8 November 2017, p. 23.

30 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

31 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 35.

3.22 There was concern expressed by RDVSA that MHS would provide coaching to first responder staff and not clinical supervision. RDVSA stated that the fundamental difference between coaching and clinical supervision is the process of 'reflective practice':

> This is a professional development technique that involves thoughtfully considering one's own experiences in applying knowledge to practice...Reflective practice is a unique part of clinical development and service delivery in the community mental health sector.[32]

3.23 RDVSA further noted:

> …coaching is future-oriented in contrast with the focus on clinical practice often being about resolving past issues…coaching is significantly more goal and action directed and structured with solutions rather than problems being the focus.[33]

3.24 NSW Women's Alliance (NSWWA) also noted MHS is providing coaching for counsellors:

> We are concerned about the apparent lack of clinical supervision to be offered to the 1800RESPECT counsellors. Clinical supervision is an integral part of best practice when working in the field of trauma. All 1800RESPECT counsellors should be accessing clinical supervision as a regular part of their work practice.[34]

3.25 The ASU outlined its concern that MHS funding of counselling staff does not extend to professional clinical supervision or professional training and development.[35]

3.26 RDVSA was also critical that MHS does not manage the vicarious trauma experienced by its staff:

> Also, as with other front line workers who contact the service, it is the position of Rape and Domestic Violence Services Australia that employers, as part of their WH&S [work, health and safety] responsibilities, must work with staff in a proactive way to manage vicarious trauma impacts. The first of these actions would be to eliminate the work from home model for staff working with trauma material and traumatised populations.[36]

3.27 The Penrith Women's Health Centre (PWHC) emphasised the risk of vicarious trauma for trauma counsellors. PWHC noted the invaluable assistance provided by RDVSA to a PWHC employed counsellor, after hours noting that PWCH:

---

32 Rape and Domestic Violence Services Australia, *Submission 57*, p. 12; See also: Wagga Women's Health Centre, *Submission 50*, p. 5.

33 Rape and Domestic Violence Services Australia, *Submission 57*, p. 12.

34 NSW Women's Alliance, *Submission 42*, p. 4. See also: Women's Domestic Violence Court Advocacy Service NSW, *Submission 17*, p. 3; EROC Australia, *Submission 15*, pp. 4 and 5.

35 Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 23

36 Rape and Domestic Violence Services Australia, *Submission 57*, pp. 22 and 48.

> …do not have access to [the Employees Assistance Program] in our Workplace so this reliance to receive support is critical.[37]

3.28 DSS advised that the support to staff includes the development wellbeing plans and access to an Employee Assistance Program to help counsellors manage against the risk of vicarious trauma.[38]

3.29 Ms Gillespie, safe steps, and Ms Diane Mangan, Chief Executive Officer, DV Connect, both indicated they did not support the first responder counsellors working from home.[39]

3.30 As to home based workers, DSS advised:

> We have also sought and received assurance in relation to the support available to home based workers, all of whom have access to a 24/7 helpline to get counselling themselves for their own vicarious trauma, and need to also access to clinical supervision in the moment that they may require it – at any given point in time that they need it…We note that they are very similar protocols that are used for the beyondblue mental health line and for other lines that are operated...[40].

3.31 However, Dr Baxter, DSS noted the concerns about home based workers raised by safe steps and DV Connect at the committee's public hearing, and indicated that DSS would work with MHS on those concerns.[41]

New panel arrangements

3.32 There was criticism of the trauma specialist panel arrangements on the basis that there will be inconsistency in approach across the different providers.[42] safe steps refuted this, stating that the three providers have worked together in recent months to ensure that the service is not only consistent '…but also the culture and leadership within each of the teams are consistent'.[43]

---

37 Penrith Women's Health Centre, *Submission 4*, p. 1. See also: Name withheld, *Submission 12*, pp. 4 and 6; Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, pp. 23–24;

38 Department of Social Services, *Submission 31*, p. 25.

39 Ms Gillespie, Chief Executive Officer, safe steps Family Violence Response Centre and Ms Diane Mangan, Chief Executive Officer, DV Connect, *Proof Hansard*, 8 November 2017, p. 32.

40 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, pp. 40–41.

41 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, pp. 40–41.

42 Name withheld, *Submission 54*, p. 1; see also Wagga Women's Health Centre, *Submission 50*, p. 3; *Announcement regarding 1800RESPECT Service*, pp. 5–6, available at: http://www.rape-dvservices.org.au/1800RESPECT, accessed 14 September 2017.

43 Ms Annette Gillespie, Chief Executive Officer, safe steps Family Violence Response Centre, *Proof Hansard*, 8 November 2017, p. 28.

3.33 DV Connect also noted:

> …we're responsible for our own professional reputations…we are responsible for the delivery of the counselling model. We have been working very closely with them [MHS] on a daily basis, with weekly teleconferences on three different tiers, and providing feedback on how we want the clinical model to look, and we have found Medibank receptive.[44]

3.34 Ending Violence Against Women believes the new panel arrangement of specialist counselling to be provided by three well-established and highly experienced services from across the country is capable of meeting the high standards of this service provision:

> These services are already providing not only crisis services to the women who seek their assistance via their helplines, but also providing counselling and in some cases face to face support.[45]

3.35 The Centre Against Sexual Violence (CASV) made a similar point:

> The CASV believes the 3 state services delivering counselling through the new 1800RESPECT will draw on their existing knowledge and expertise and employ a pool of appropriately qualified, skilled and experienced workers to provide safe, high quality, trauma informed, woman centred care.[46]

3.36 safe steps has advised that, as statewide providers, it has long held the view that the 1800 RESPECT service would be best delivered as a truly national collaboration between like-minded not-for-profit providers:

> This would likewise strengthen the referral process between the national trauma counselling service and statewide services.[47]

3.37 When asked to respond to concerns regarding the qualifications of the new panel providers, Dr Linda Swan, Chief Medical Officer, Medibank stated:

> I think their own record speaks for themselves. I have every confidence in the quality of the counsellors that are employed by these organisations. They have a long history of delivering these types of services. They do so for a range of services above and beyond this one. I think to question the professional integrity of those groups is the wrong thing to do. I think that we should be telling Australians that we have a high-quality service available for them to contact experienced counsellors when they are in need

---

44 Ms Diane Mangan, Chief Executive Officer, DV Connect Queensland, *Proof Hansard,* 8 November 2017, p. 29.

45 Ending Violence Against Women, *Submission 53,* p. 1; See also: Australian Women Against Violence Alliance, *Submission 40,* p. 2.

46 Centre Against Sexual Violence, *Submission 51,* p. 2; See also: Red Rose Foundation, *Submission 19,* pp. 3–4.

47 Ms Annette Gillespie, Chief Executive Officer, safe steps Family Violence Response Centre, *Proof Hansard,* 8 November 2017, p. 27.

> and we shouldn't be in a position of trying to question the competency of organisations that have been running in statewide organisations for many, many years.[48]

Service should be provided by a not-for-profit operator

3.38 Many working in the community sector are adamant that it is not appropriate for the 1800 RESPECT service to be delivered by a for-profit organisation:

> Profit making for shareholder dividend from vulnerable women is unethical, immoral and not acceptable. Service provision is subject to cost cutting so that profits can be gained by the service provider…[49]

3.39 Dr Ses Salmond noted the role for advocacy in the not-for-profit community sector:

> The current role of delivery of the 1800RESPECT line by MHS, by virtue of its focus on triage, will miss action on a crucial role of the not for profit NGOs [non-Government organisations], opportunities to advocate for better service delivery for this group of vulnerable and marginalised clients.
>
> Furthermore, a for profit service will be unlikely to identify and advocate against systemic abuse and systematic failures which are currently identified and taken up by counsellors employed by RDVSA.[50]

3.40 The ASU contended that there should be no further marketization of the not-for-profit social and community services sector, and that there should be an end to competitive tendering as a means of allocating funding to the social and community sector.[51] Ms Natalie Lang, Branch Secretary of the ASU argued that non-government organisations 'are born of a mission to advocate' on behalf of others, noting that:

> …the United Nations takes a very public view that, in addressing gendered violence, government should work with non-government organisations and fund non-government organisations to provide these services, because they're an essential player in democracy.[52]

---

48 Dr Linda Swan, Chief Medical Officer, Medibank, *Proof Hansard*, 8 November 2017, pp. 18–19.

49 Bankstown Women's Health Centre, *Submission 1*, p. 1. See also: Ms Judith Shepherd-Pemell, *Submission 6*, p. 1; Ms Paula Martin, *Submission 7*, p. 1; National Council of Women of South Australia, *Submission 9*, p. 2; Women's March Sydney, *Submission 20*, p. 4; Women's Health Tasmania, *Submission 21*, p. 3; Ms Marisol Pacheco, *Submission 55*, p. 2; NSW Women's Alliance, *Submission 42*, p. 3; Australian Council of Trade Unions, *Submission 38*, p. 3; Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 31.

50 Dr Ses Salmond, *Submission 30*, p. 4.

51 Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 31. See also, Dr Ses Salmond, *Submission 30*, p. 3.

52 Ms Natalie Lang, Branch Secretary, Australian Services Union NSW & ACT (Services), *Proof Hansard*, 8 November 2017, pp. 3–4. See also: Women's Health NSW, *Submission 32*, p. 4.

Privacy, confidentiality and consent issues

3.41 The committee received some evidence which dealt with concerns about the handling of personal information by MHS and the specialist trauma counselling panel providers.

MHS request for RDVSA client files

3.42 RDVSA noted that it objected to MHS's request that RDVSA handover all its client files to MHS without consent; RDVSA considered that a complete handover of those records is not in keeping with trauma, confidential, privacy and ethical practice.[53] RDVSA stated:

> Medibank is well aware of the standard clinical practices Rape and Domestic Services Australia has in place to transfer file information to other providers and could seek to engage in that process rather than demand a complete handover.[54]

3.43 The Wagga Women's Health Service expressed concern that RDVSA would be required to hand over all existing 1800 Respect service client files:

> In my knowledge and experience this is unethical practice that affects the professional obligations of counsellors and it has the potential to undermine the trust and confidence clients have in an organisation and in the processes involved. This can create a triggering response in clients causing distress and relapse in their journey with trauma.[55]

3.44 The Psychotherapy and Counselling Federation of Australia (PACFA) also noted that disclosure of past client's files would be in breach of the PACFA Code of Ethics as clients have not agreed to such disclosure.[56]

3.45 In response, Dr Baxter, DSS, stated:

> It is important to remember why these files, which are files of the 1800RESPECT service, not of RDVSA, matter. They ensure that people who call the service again do not have to retell their story…These files have the highest degree of privacy protection. They belong to the 1800RESPECT service.[57]

---

53 Rape and Domestic Violence Services Australia, *Submission 57,* p. 4.

54 Rape and Domestic Violence Services Australia, *Submission 5,* p. 42.

55 Wagga Women's Health Centre, *Submission 50,* p. 4. See also Women's Legal Service NSW, *Submission 14,* p. 2–3; Fair Agenda, *Submission 34,* p. 1; and Psychotherapy and Counselling Federation of Australia, *Submission 10,* p. 3.

56 Psychotherapy and Counselling Federation of Australia, *Submission 10,* p. 3.

57 Dr Roslyn Baxter, Group Manager, Families Group. Department of Social Services, *Proof Hansard,* 8 November 2017, p. 36.

Related concerns

3.46 RDVSA'S refusal to accede to MHS's request to relinquish its counselling files on its withdrawal from providing the trauma counselling component of the 1800 Respect Service sparked a number of related issues concerning MHS client management systems.

3.47 The ASU considered that there are serious concerns around security and confidentiality of clients' files, on-line counselling information and other records which are used by MHS call-centre first responders.[58] The ASU referred specifically to the common management system, which allows staff from all services participating in the new model of delivery to have access to the electronic files for everyone who contacts the 1800 RESPECT service.[59] The WDVCAS is also concerned about all organisations having access to all of the clients' files, noting that 'MHS has a poor record of maintaining the safety of client files'.[60]

3.48 As for home-based MHS employees, the ASU expressed concern that sharing a home with a telephone and online counsellor makes it more than probable that others will hear or observe the counselling.[61] One submission observed:

> …I understand that several MHS phone counsellors work from a home office. This presents massive privacy and confidentiality concerns for me as it is impossible to know whether there are people present in the home or how privacy is ensured within that setting.[62]

3.49 In response, DSS has stated:

> So, we are assured [by MHS] in terms of privacy, the technological and support systems set up for home based workers are robust. We have had people check out those processes and ensure that they are able to maintain the privacy and confidentiality of callers.[63]

3.50 The Red Rose Foundation stated that women calling the 1800 RESPECT service should be provided with information on the recording and storage of information.[64] The PACFA contended that client records should only be kept for appropriate purposes:

> i.e. for the benefit of the client.

---

58 Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 24. See also: NSW Women's Alliance, *Submission 42*, p. 1.

59 Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 24. See also: Leichardt Women's Community Health Centre, *Submission 43,* p. 2.

60 Women's Domestic Violence Court Advocacy Service NSW, *Submission 17*, p. 1.

61 Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 24. See also: Leichardt Women's Community Health Centre, *Submission 43,* p. 2.

62 Name withheld, *Submission 12*, pp. 2–3.

63 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard,* 8 November 2017, p. 40.

64 Red Rose Foundation, *Submission 19*, p. 1.

> Contract monitoring and quality assurance are not purposes for which clients records should be kept or disclosed. In in particular, the recording of sessions for the purpose of contract monitoring does not relate to client needs and does not respect client confidentiality. [65]

3.51 In relation to privacy, DSS advised there have been no changes to the privacy provisions as a result of the new panel arrangements:

> The same provisions will continue to apply that have been in existence since the establishment of the service in 2010. MHS is required under our contract with them to meet privacy standards as stringent as those that apply to an Australian government department.[66]

Recording of 1800 RESPECT calls

3.52 The Australian Psychological Society (APS) questioned the legality of recording the 1800 Respect service interactions, noting that it is potentially illegal in some states, even where you are a party to the conversation.[67] The APS continued:

> …[we are] gravely concerned that requiring the recording of counselling sessions will have unintended consequences and may as a disincentive for a highly vulnerable population of victims of family violence and sexual assault to remain and engage with appropriate trauma counselling services.[68]

3.53 The PACFA concurred with APS's view, observing that it:

> …assumes that when seeking to record counselling sessions, clients would be given the option to "opt out" of recording. This would be essential otherwise it takes away the clients' right to informed consent for any services they receive.[69]

3.54 The Red Rose Foundation contended that women calling the 1800 RESPECT service:

> should be informed that there no requirement to disclose personal information, noting that many callers to current domestic violence and sexual assault service(s) do not identify who they are, especially in the first

65 Psychotherapy and Counselling Federation of Australia, *Submission 10,* p. 3.

66 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard,* 8 November 2017, p. 36.

67 Australian Psychological Society, *Submission 56,* p. 5. See also, Illawarra Forum, *Submission 24,* p. 2;

68 Australian Psychological Society, *Submission 56,* p. 5. See also: Women's Health Tasmania, *Submission 21,* p. 2.

69 Psychotherapy and Counselling Federation of Australia, *Submission 10,* p. 3.

> instance. Not providing personal identifying information should never be a barrier to service.[70]

3.55 DV Connect noted callers are able to remain anonymous or provide a pseudonym. DV Connect also observed that the recording of calls in the domestic violence sector is current practice, but again, every caller is able to ask that their call not be recorded.[71]

3.56 As to the recording of conversations, Dr Baxter stated:

> No caller is ever required to have their call recorded or to identify themselves if they choose to have it recorded. Further, at any point callers can advise that they no longer wish to have their call recorded. This will not affect the service they receive in any way.[72]

3.57 MHS also advised that callers to the 1800 RESPECT service are advised that they do not have to have their calls recorded:

> Callers also have the option to remain anonymous, to use a pseudonym, or withhold identifying information…Only 10 per cent of callers provide both a first and a last name.
>
> Callers will continue to have access to all these options under the new panel arrangements for trauma specialist counselling services.[73]

Subpoenas and the sexual assault communications privilege

3.58 Bankstown Women's Health Centre questioned the ability of the 1800 RESPECT service under the MHS First Response model to gather recorded information from clients that is safe from subpoena by perpetrator's lawyers.[74] The National Council of Women of South Australia observed that women who call the 1800 RESPECT number:

> Need to know their conversations are private and confidential and not able to be used in court or for any other purpose that may place them at further harm.[75]

---

70 Red Rose Foundation, *Submission 19*, p. 2. See also: Centre Against Sexual Violence, *Submission 51*, pp. 1–2.

71 DV Connect, Queensland, *Submission 47*, p. 4.

72 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 36.

73 Medibank, *Submission 29*, p. 12.

74 Bankstown Women's Health Centre, *Submission 1*, p. 1. See also: The Australian Women's Health Network, *Submission 2*, p. 2; National Council of Women of South Australia, *Submission 9*, p. 2; Name withheld, *Submission 11*, p. 1; Name withheld, *Submission 12*, pp. 2–3; Wagga Women, 50, p. 4; See also: Women's Domestic Violence Court Advocacy Service NSW, *Submission 17*, p. 2.

75 National Council of Women of South Australia, *Submission 9*, p. 2; See also: WILMA Women's Health, *Submission 22*, p. 1; Women's Health Centre, *Submission 28*, p. 1; Victorian Women's Trust, *Submission 33*, p. 2; Women's March, Sydney, *Submission 20*, p. 3; Red Rose Foundation, *Submission 19*, p. 1.

3.59 RDVSA noted that future file notes are to be recorded on the MHS system which also records all voice interactions. It contends that these records may be subjected to subpoena without challenge and would be accessed by any number of staff across a number of organisations.[76] RDVSA observed that it always challenged subpoenas and had a 100 per cent success rate.[77]

3.60 However, other organisations noted that there was always the potential for information to be subpoenaed, no matter what the service. The Gold Coast Centre Against Sexual Violence made the point:

> There has always been the potential to subpoena women's files and recordings. Queensland services have experience and expertise in responding to subpoenas…[78]

3.61 DV Connect stated that it responds to many subpoenas each year:

> …and understand our responsibility to the recording of client information especially when a name is provided.[79]

3.62 safe steps also indicated it has a 100 per cent success rate in defending subpoenas and that they are 'committed absolutely to protecting the safety and confidentiality of the women we work for'.[80]

3.63 A number of organisations expressed concern as to MHS's application of the sexual assault communications privilege.[81] Women's Health NSW made the point:

> The implementation of these protections [confidentiality, privacy, and sexual assault communications privilege] relies on the decision of the 'practitioner or the company in possession of the clients files' to choose to implement them…[82]

3.64 Ending Rape on Campus contended that MHS has made it clear that it will not engage in the communications privilege actions if clients files are subpoenaed:

> When calling crisis lines such as the service, people who have experienced sexual violence often express self-blame for their abuse and due to the stance taken by MHS, this could be used as evidence against survivors should their case be heard before the court.[83]

---

76 See: *Announcement regarding 1800RESPECT Service*, p. 1, available at: http://www.rape-dvservices.org.au/1800RESPECT, accessed 14 September 2017.

77 Rape and Domestic Violence Services Australia, *Submission 57*, pp. 4 and 29.

78 Gold Coast Centre Against Sexual Violence, *Submission 36***,** p. 3.

79 DV Connect Queensland, *Submission 47*, p. 4.

80 Ms Annette Gillespie, safe steps Family Violence Response Centre, *Proof Hansard*, 8 November 2017, p. 28.

81 NSW Women's Alliance, *Submission 42*, p. 2. See also: Fair Agenda, *Submission 34*, p. 1.

82 Women's Health NSW, *Submission 32*, p. 5.

83 End Rape on Campus Australia, *Submission 15*, p. 3.

3.65 MHS advised that it would certainly object to a subpoena, however, it noted that it is subject to the law. MHS indicated that it is prepared to put in the resources and time to deal with subpoenas, noting:

> …it's also really important on this to look at how many records are potentially able to be subpoenaed. Most of the callers to 1800RESPECT do not provide identifying information. That's the case with the majority of our callers, and those records could not be subpoenaed. There are a small number that could potentially be subpoenaed. As I have said, we've never had a request for a subpoena since we've been delivering the first response.[84]

3.66 The Women's Legal Service Queensland also noted that it understands the majority of current callers are anonymous. It also considered that issues around the use of the sexual assault counselling privilege can be worked out in contractual arrangements or an MOU between the funded service providers and MHS.[85]

3.67 On the issue of subpoenas, DSS stated:

> RDVSA have said that only they will commit to resist subpoenas. MHS are on the public record saying that they would use all powers and privileges to refuse sharing information, including in the case of subpoenas.[86]

3.68 The committee noted with concern that under questioning MHS was unable to clearly state whether or not a written organisational policy is in place which sets out how MHS will respond to subpoenas. MHS provided written documents in response to a question on notice after the hearing.[87] These documents provide general information yet do not provide a clear statement or direction to staff to automatically make a claim for sexual assault communications privilege.

---

84 Ms Nicole McMahon, General Manager, 1800RESPECT, Medibank, *Proof Hansard,* 8 November 2017, p. 26; See also: Ms Justine Cain, Divisional General Manager, Medibank Health, Medibank, *Proof Hansard,* 8 November 2017, p. 26.

85 Women's Legal Service Queensland, *Submission 49*, p. 3.

86 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard,* 8 November 2017, p. 36.

87 Medibank, Answer to a question on notice, pp. 12–13, received 15 November 2017.