The Senate

Finance and Public Administration References Committee

Delivery of National Outcome 4 of the National Plan to Reduce Violence Against Women and Their Children 2010-2022

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List of Recommendations

Recommendation 1

4.10 The committee recommends that the Government ensure that 1800 RESPECT first response triage counsellors and trauma counsellors have adequate qualifications and experience and an appropriate work environment. Specifically that:

- **The 1800 RESPECT first response triage service is staffed only by counsellors with a minimum three year tertiary degree in counselling or equivalent and a demonstrated minimum three years' experience in specialised counselling in family domestic violence and sexual assault counselling and working with clients from diverse backgrounds and locations.**
- **The committee recommends that the government review the working arrangements for first response counsellors employed by Medibank Health Solutions, and intervene to ensure that:**
    - **first responders receive appropriate initial and ongoing training;**
    - **appropriate clinical supervision is provided;**
    - **the practice of working from home cease; and**
    - **policies and procedures aimed at protecting clients, and also those aimed at protecting responders from vicarious trauma, are implemented.**
- **More broadly, the committee recommends that the government consider whether having a principal contractor, rather than the specialist services themselves, providing first responder services represents value for money and best-practice.**

Recommendation 2

4.11 In respect of the trauma specialist counsellors, the committee recommends:

- **that sufficient funding be made available for the telephone counselling function of the 1800 RESPECT to ensure that there are sufficient specialist trauma counsellors to meet current and future demand for counselling, having regard to both quantitative and qualitative performance measures.**

Recommendation 3

4.18 The committee notes that many of the procurement and accountability issues revealed in this inquiry are the remit of the Australian National Audit Office (ANAO) and strongly recommends that the government management of the program and its procedures is reviewed by the ANAO.

Recommendation 4

4.19 The committee recommends that the Department of Social Services develop an evaluation schedule for the 1800 RESPECT program and release a high level evaluation plan that includes the quantitative and qualitative performance measures the contractors and sub-contractors will be measured against.

Recommendation 5

4.20 The committee recommends the Department of Social Services brief its staff and contractors on their legal and contractual requirements in program management and Senate Standing Orders.

Recommendation 6

4.21 The committee further recommends that the government consider whether the principal contractor model, as currently arranged, represents value for money and best-practice. Specifically, the committee recommends that the government consider whether the value of the contract management services provided by Medibank Health Solutions (MHS) justifies the public funding provided to MHS for that purpose, or whether that is a function that would be better provided by government, with MHS retaining responsibility for the technological (telephony and online) aspects of the program.

Recommendation 7

4.26 The committee recommends that the Department of Social Services require Medibank Health Solutions to develop 1800 RESPECT specific privacy information that clearly explains how personal information will be recorded and maintained. The privacy information will detail what the individual's options are, including opting out of recordings and remaining anonymous.

Recommendation 8

4.27 The committee recommends that the Department of Social Services (DSS) require Medibank Health Solutions (MHS) to develop a clear statement for the 1800 Respect website detailing:

- **how MHS manages information, voice records and files; and**
- **relevant information on the extent and limitations of privacy and confidentiality in a manner that they potential callers can fully understand.**
- **that the DSS develop a clear, written protocol on handling of subpoenas and applying for privilege for MHS and subcontractors by March 2018.**
- **that staff are informed of these protocols and their requirements.**
- **that this protocol is made available on the 1800 RESPECT website.**

Chapter 1

Referral

1.1 On 11 September 2017, the Senate referred the following matter to the Senate Finance and Public Administration References Committee (committee) for inquiry and report by 14 November 2017:

> The delivery of National Outcome 4 of the National Plan to Reduce Violence Against Women and Their Children 2010-2022, 'Services meet the needs of women and their children experiencing violence', insofar as that Outcome is given effect by the 1800 RESPECT Domestic and Sexual Violence National Counselling Service ("the service"), with particular reference to:

(a) The adequacy and quality of counselling provided, including:

(i) The funding made available for counselling,

(ii) The counselling model and associated counselling practices,

(iii) The protection of privacy and confidentiality for those who use the service,

(iv) The efficiency and appropriateness of the triage model adopted in relation to the service in 2016, and

(v) The infrastructure required for the provision of the service;

(b) The procurement arrangements for the service, including contractual and tender arrangements;

(c) The engagement of staff and contractors, including:

(i) Their qualifications and working conditions,

(ii) The professional standards and ethical obligations applicable to those providing the service, and

(iii) The oversight and quality assurance undertaken in relation to those providing the service;

(d) Evaluation arrangements for the service;

(e) Best practice for domestic and sexual violence counselling; and

(f) Any other related matters.[1]

1.2 The reporting date was subsequently extended to 15 December 2017.[2]

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1 *Journals of the Senate, No. 60*—11 September 2017, p. 1933.

2 *Journals of the Senate No. 68*—13 November 2017, p. 2191; *Journals of the Senate No.72*—27 November 2017, p. 2283; and *Journals of the Senate, No 76*—p. 2428.

Conduct of the Inquiry

1.3 Details of the inquiry were placed on the committee's website at: www.aph.gov.au_fpa. The committee directly contacted relevant organisations and individuals to notify them of the inquiry and invite submissions by 6 October 2017. Submissions received by the committee are listed at Appendix 1.

1.4 A public hearing was held in Sydney on 8 November 2017. A list of witnesses who gave evidence at the hearing is available at Appendix 2. The Hansard transcript may be accessed through the committee's website.

Background

1.5 Australia's framework to address domestic and family violence is set out in the *National Plan to Reduce Violence Against Women and Their Children 2010–2022* (the National Plan).[3] The National Plan was endorsed by the Council of Australian Governments, and released in February 2011. It comprises four discrete phases, each of three years duration, for delivery over its twelve year term. There are six National Outcomes:

1. Communities are safe and free from violence
2. Relationships are respectful
3. Indigenous communities are strengthened
4. Services meet the needs of women and their children experiencing violence
5. Justice responses are effective
6. Perpetrators stop their violence and are held to account.

1800 RESPECT national telephone counselling service

1.6 In 2010, in anticipation of the development of the National Plan, the Commonwealth provided funding for a national helpline, 1800 RESPECT for victims of domestic and family violence. The 1800 RESPECT service was later incorporated in the First Stage Plan of the National Plan, *'Building a Strong Foundation'*, as the first national domestic and family violence and sexual assault counselling service, falling within Outcome 4.

1.7 As noted above, Outcome 4 of the National Plan requires that 'services meet the needs of women and their children experiencing violence'. Success of Outcome 4 is to be measured by:

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3 This section draws upon *The Australian Government's National Plan to Reduce Violence against Women - Immediate Government Actions, April 2009*, the *National Plan to Reduce Violence Against Women and their Children 2010-2022,* as well as the Senate Finance and Public Administration References Committee Report, *Domestic Violence in Australia,* August 2015, and the submission by the Department of Social Services (*Submission 57*) to the 2015 inquiry.

> … an increase in the access to, and responsiveness of, services for victims of domestic and family violence and sexual assault.[4]

1.8 The Department of Social Security (DSS) has responsibility for the delivery of the 1800 RESPECT service under the National Plan. DSS appointed the Government Business Enterprise Medibank Health Solutions (MHS) as the service provider from 8 July 2010 with a multiyear funding agreement until 30 November 2014.[5]

1.9 DSS and MHS have provided the committee with the funding agreements, subcontracting agreements, and related documents, that were in place between the various organisations. The committee has accepted these documents in camera and does not intend to release those documents however the committee has drawn some general information from those documents to form part of this report.

1.10 The July 2010 agreement required that MHS subcontract the NSW Rape Crisis Centre to deliver the counselling services for the national online and 1800 RESPECT counselling service.

1.11 The second funding agreement between DSS and MHS commenced on 1 January 2014 with an end date of 30 June 2017. The agreement required that MHS subcontract the Rape and Domestic Violence Services Australia (RDVSA) to deliver the counselling services for the national online and 1800 counselling service.

1.12 MHS was privatised and listed on the Australian Stock Exchange on 25 November 2014.

1.13 The second subcontract between MHS and RDVSA commenced on 1 January 2014 with an end date of 30 June 2017.[6]

1.14 This subcontract was varied effective 1 July 2015 and additional funding was provided with the requirement to increase the Critical Service Levels over the next two years.

1.15 The subcontract between MHS and RDVSA was extended by 120 days from 30 June 2017 to 31 October 2017.

1.16 In its submission DSS stated that it selected MHS to provide the 1800 RESPECT service based on its substantial telephony and digital infrastructure:

> The expertise and resources needed to build and maintain the operating infrastructure of the scale needed was one of the reasons the service was outsourced to the private sector and is one of the major strengths MHS

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4 *The National Plan to Reduce Violence against Women and their Children 2010–2022*, p. 23.

5 Department of Social Services, Schedule — Standard Funding Agreement, 8 July 2010 to 30 November 2014, *in camera* answer to question on notice, received 16 November 2017.

6 Agreement between MHS and RDVSA, dated 31 July 2014, *in camera* answer to question on notice, received 27 November 2017.

> brings to 1800RESPECT, as a leading provider of telephone and online health services.[7]

Current Grant Agreement between DSS and MHS

1.17 The Grant Agreement between DSS and MHS is a funding agreement in the nature of a contract.[8] The current Grant Agreement commenced on 1 January 2014 and is due to expire on 31 December 2019.[9] A variation to the agreement was executed on 21 July 2017, which *inter alia*, removed the requirement by DSS for MHS to subcontract to RDVSA for the national online and 1800 counselling service.

1.18 MHS's funding of RDVSA covered all aspects of the delivery of the 1800 RESPECT service, including supporting the training and professional development of counsellors, with overarching infrastructure and the delivery of other components of the 1800 RESPECT service being provided by MHS.[10]

Responding to increasing demands on the 1800 RESPECT service

1.19 DSS ascertained that in the 2014–2015 financial year, there was increasing demand on the 1800 RESPECT counselling service. Of the 52 431 calls received by the service, only 14 899 were answered (28 per cent), with 37 352 callers unable to access support when they needed it (72 per cent). Further, an additional 10 747 voicemails were also received by the service.[11]

1.20 In November 2015, DSS engaged KPMG to undertake an independent review of the 1800 RESPECT service and provide options to improve service responsiveness.[12] KPMG found the increase in community awareness and government focus on domestic and family violence had changed the landscape the 1800 RESPECT service was operating within, with the result that:

> The increased public awareness of 1800RESPECT required it to operate not only as a best practice counselling service, but also as an effective 'first responder', capable of managing a wider variety of calls and needs.[13]

1.21 After identifying that the existing operating model 'was no longer fit for purpose', KMPG identified three possible options to improve service delivery:

> 1. <u>Increasing funding for the existing operating model</u> – this option would provide additional RDVSA staff to answer more calls and respond to voicemails more efficiently.

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7 Department of Social Services, *Submission 31*, p. 21.

8 Ms Kathryn Mandla, Principal Adviser, Department of Social Services, *Proof Hansard*, 8 November 2017, p. 36.

9 Department of Social Services, *Submission 31*, p. 21.

10 Medibank, *Submission 29*, pp. 5 and 7.

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

12 Department of Social Services, *Submission 31*, p. 18.

13 Department of Social Services, *Submission 31*, p. 18.

2. A first responder triage model – this option proposed qualified social workers or counsellors to answer calls as soon as possible and take immediate action as required.

3. A trauma specialist triage model – this option comprised RDVSA providing two differently focused trauma specialist counselling services, one focused on crisis intervention and referral and the other on more in-depth counselling.[14]

1.22 In August 2016, the 'First Response' triage model was adopted, where qualified social workers or counsellors are employed by MHS to answer calls as soon as possible, conduct a needs analysis and take immediate action as required. Immediate action may include engaging 000 or another emergency service, a 'warm transfer' to a trauma specialist counsellor, or referral to a state based or local service provider. A 'warm transfer' is a handover from the 1800 RESPECT call line to a trauma specialist counsellor without the caller having to retell their story.[15] RDVSA continued to undertake the trauma specialist counselling aspect of the 1800 RESPECT service on referral.[16]

1.23 At the public hearing, Ms Karen Willis, Executive Officer, RDVSA, explained the difference between the two service models:

> From October 2010 through to 16 August 2016, all calls to the 1800 Respect line came to our trauma counsellors. On 16 August 20016, the triage model was introduced. At that point all calls went to Medibank Health Solutions, and then they decided which of those calls would be forwarded through to us, and which would be diverted to other locations, services, websites etcetera.[17]

1.24 DSS advised that the First Response approach resulted in a 172 per cent increase in the number of telephone and online contacts answered, and the average waiting time was reduced from over 10 minutes to 37 seconds.[18]

1.25 On the introduction of the First Response triage model in August 2016, RDVSA answered the calls referred to them by the first response counsellors for callers that required trauma specialist counselling. RDVSA continued discussions with MHS to identify necessary steps to increase the number of calls answered.

1.26 MHS submitted that more than 20 per cent of those critical calls were not answered by RDVSA:

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14 Department of Social Services, *Submission 31*, p. 19. The trauma specialist triage model was proposed by RDVSA, and operated for the period from April – August 2016. See: RDVSA, *Submission 57*, pp. 4–5.

15 Department of Social Services, *Submission 31*, pp 11 and 19.

16 Medibank, *Submission 29*, p. 4.

17 Ms Karen Willis, Executive Officer, Rape and Domestic Violence Services Australia, *Proof Hansard*, 8 November 2017, p. 10.

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

> At the time the new arrangement [the First Response model] was announced, approximately 22 per cent of all calls requiring trauma specialist counselling were going unanswered by R&DVSA, which is subcontracted to deliver that component of the service. R&DVSA itself indicated to the Australian Government that it would be unable to address this abandonment rate and there would continue to be unacceptably long wait times for this important service. Medibank could not accept that so many callers in need of trauma specialist counselling would continue to be unable to access it at the time of calling.[19]

1.27 On 31 January 2017, MHS sought agreement with DSS 'to go to the market' for the trauma specialist counselling component of the 1800 RESPECT service. The approach was an initial expression of interest (EOI), followed by a Request for Proposal (RFP).[20] Three organisations were invited to take part in the RFP process which ran from February–August 2017; during this period there were further discussions and negotiations with the 'preferred respondent'.[21]

1.28 MHS stated:

> The objective of the RFP process was to enable a review of trauma specialist counselling skills available nationally so that Medibank could be confident it was providing the best possible trauma counselling and to understand and plan as to how it might meet future demand. The RFP also provided an opportunity to enter a new trauma specialist counselling subcontract that would more accurately reflect the revised subcontracting arrangements under a First Response model.[22]

1.29 In February 2017, MHS initiated a RFP process to establish a panel of providers to deliver the trauma specialist counselling component of the 1800 RESPECT service.[23]

1.30 MHS approached the market with a RFP on 14 March, 2017 requiring an intent to respond form by 20 March, 2017, an interim submission by 28 March 2017, and a response closing date of 19 April, 2017.

1.31 MHS stated in its submission to the inquiry that the outcome of the RFP process was that no subcontract was awarded, adding that this outcome was permitted under the terms of the RFP.[24] It is not clear from the MHS submission and

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19 Medibank, *Submission 29,* p. 4.

20 Medibank, *Submission 29,* p. 17; Department of Social Services, *Submission 31,* p. 34.

21 Medibank, *Submission 29,* p. 17. RDVSA was a preferred respondent.

22 Medibank, *Submission 29*, p. 5.

23 Medibank, *Submission 29,* p. 4. The not-for-profit panel providers selected to deliver the trauma specialist counselling component of the 1800 RESPECT service in place of RDVSA are safe steps Family Violence Response Centre, Victoria, DVConnect, Queensland and Women's Safety Services South Australia. The Blue Knot Foundation, NSW, has been engaged to deliver training and professional development to trauma specialist counsellors from the panel organisations: see Medibank, *Submission 29,* pp. 6 and 9–11.

24 Medibank, *Submission 29*, p. 5.

correspondence if and when this was communicated to RDVSA and if it was before MHS signed agreements with three other providers on 9 July 2017.

1.32 Following the RFP process MHS negotiated with four service providers: RDVSA, safe steps Family Violence Response Centre (safe steps), DV Connect and Women's Safety Services SA (WSSSA). MHS signed agreements with DVConnect, safe steps and WSSSA on 9 July 2017 to commence 14 August, 2017 and to provide counselling services from 24 October, 2017 with a contract end date of 31 December, 2019.

1.33 MHS wrote to RDVSA on 19 May 2017 advising them that they had been selected as a preferred respondent and inviting RDVSA to enter preliminary negotiations and proposing an extension of the service to 31 October 2017, to facilitate negotiation of the proposed subcontract.

1.34 On 10 August 2017, MHS announced a new arrangement of panel of sector-based, not-for-profit organisations to provide the trauma specialist counselling component of the 1800 RESPECT service. RDVSA was included on the panel arrangements with the three other service providers.[25] The Blue Knot Foundation was engaged to provide training.[26]

1.35 On 30 August 2017, RDVSA made a public announcement that it was withdrawing from the panel appointment process for the 1800 RESPECT service, with its participation finishing on 28 October 2017:

> Only after considerable negotiation with the lead agency, Medibank Health Solutions (MHS), did the Board of Rape & Domestic Violence Services Australia come to the conclusion that accepting the sub-contract and the new MHS service model would be inconsistent with the values, ethics, quality counselling practices and work place relations that are foundational to our organisation and culture.[27]

1.36 On 19 September 2017 MHS signed variation agreements with the three remaining subcontractors, safe steps, DVConnect and WSSSA, to increase staff and workload.

1.37 The report is structured as follows:

- Chapter 2 discusses governance and accountability issues between the various parties involved in the delivery of the 1800 RESPECT service;
- Chapter 3 canvasses issues specific to the introduction of the First Response model of service and concerns in relation to privacy issues;

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25 Medibank, *Submission 29*, pp 5–6; Department of Social Services, *Submission 31*, p. 34. The three organisations are: DV Connect, Queensland; safe steps, Family Violence Response Centre, Victoria; Women's Safety Service, South Australia.

26 Medibank, *Submission 29*, pp. 5–6.

27 See: *Announcement regarding 1800RESPECT Service,* http://www.rape-dvservices.org.au/1800RESPECT, accessed 14 September 2017; Medibank, *Submission 29*, p. 6.

- Chapter 4 sets out the committee view and recommendations.

Chapter 2

Governance and accountability issues

Introduction

2.1 The chapter discusses:

- concerns about the procurement process for the trauma specialist panel leading to RDVSA's withdrawal from delivery of the 1800 RESPECT service;
- the accountability of DSS and MHS for the delivery of the 1800 RESPECT service;
- clinical governance of the new panel of providers for trauma specialist counselling.

The procurement process

2.2 RDVSA specialises in trauma specialist counselling, providing evidence based, best practice service underpinned by national and international robust and peer reviewed research.[1] Until August 2016, RDVSA was the sole provider of the counselling component of the 1800 RESPECT service as a sub-contractor on behalf of MHS.[2] Ms Karen Willis, Executive Officer, RDVSA, explained how that organisation came to be the sole clinical service provider for the 1800 RESPECT service from 2010:

> I think it was a tender process undertaken by the Australian government. I think there was an expression of interest and a tender process, and the government decided that Medibank Health Solutions, which was then a government agency, would be the lead agency because they had the telephony infrastructure. They were directed by contract to subcontract the trauma counselling work to Rape and Domestic Violence Services Australia.[3]

2.3 Mr Adair Donaldson, a lawyer who provides pro bono legal support and training for RDVSA staff, provided further insight on how RDVSA came to be selected to provide the 1800 RESPECT service:

> The RDVSA, (and its predecessor the NSW Rape Crisis Centre) for at least the last 15 years have been the peak body and advisory organisation dealing with rape and domestic violence nationally. It was the Howard Government that showed leadership in 2004 when it established the need for the first specialist 24/7 telephone counselling service. The Government engaged with the then NSW Rape Crisis [Centre] through its role with the National Association of Services Against Sexual Violence…In 2009 when Medibank

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

2 Medibank, *Submission 29*, pp. 5 and 7.

3 Ms Karen Willis, Executive Officer, Rape and Domestic Violence Services Australia, *Proof Hansard,* 8 November 2017, p. 10.

> Private was awarded the lead agency role for the administration of the 1800RESPECT service there was a direction that RDVSA would be contracted to provide the critical service.
>
> What this history highlights is the esteem in which RDVSA has been held by past federal governments that have recognised the specialised nature of the service. That is, there has always been mutual respect from government (state and federal) and the RDVSA.[4]

2.4 Submissions attest to the RDVSA being held in very high regard in the not-for-profit women's health sector, particularly as to its service model.[5]

2.5 In light of the unmet demand for the 1800 RESPECT service, in November 2015, DSS had engaged KPMG to undertake the independent review of the 1800 RESPECT operating model to address the issue of the responsiveness of the service.[6] Concurrently, the National Plan required an evaluation of the national 1800 RESPECT service to be undertaken in the first half of 2016 to inform the sub-contract renewal process.[7]

Criticisms of the procurement process

2.6 The committee heard a range of evidence about the changes to the MHS subcontracting model for the 1800 RESPECT service, as well as the requirement, transparency and short timeframes of the EOI and RFP processes. RDVSA raised concerns about the lack of information about the new process and the new panel model.

2.7 RDVSA contended that the EOI and RFP process for the renewal of the sub-contract between MHS and RDVSA was not only unnecessary, but also that it was undertaken without good faith.[8] RDVSA outlined various specific concerns.[9]

2.8 In particular, RDVSA argued that it was not necessary to go through the RFP or 'tender' process:

> It should be noted that for the contract entered into in 2014 there was no requirement by [MHS] that the [1800 Respect] service go to tender.[10]

4 Mr Adair Donaldson, *Submission* 61, p. 4.

5 Australian Services Union NSW & ACT (Services) Branch, *Submission 58,* p. 16. See also, for example: Women's Health Tasmania, *Submission 21,* p. 2; Women's March Sydney, *Submission 20,* pp 3–4; Name withheld, *Submission 11,* p. 1; The Sydney Feminists, *Submission 5*, p. 1.

6 Department of Social Services*, Submission 31*, p. 18.

7 Rape and Domestic Violence Services Australia, *Submission 57*, p. 38. The National Plan evaluation was undertaken by Social Compass.

8 Rape and Domestic Violence Services Australia, *Submission 57*, pp. 40–41. See also Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, p. 31.

9 Rape and Domestic Violence Services Australia, *Submission 57*, pp. 4–5, 31, 39 and 41.

10 Rape and Domestic Violence Services Australia, *Submission 57*, p. 39.

2.9 RDVSA observed that non-government organisations (NGOs) do not have vast resources at their disposal, and to large extent rely on the goodwill of staff and volunteers who contribute at all levels in an organisation:

> Therefore, the process of tendering is perhaps more arduous for NGOs compared to large private or public sector bureaucracies who are better resourced.[11]

2.10 RDVSA also argued that prior to 10 August 2017, MHS had not indicated that it intended to implement a totally new model of service provision, with a panel of organisations providing the specialist trauma counselling for the 1800 RESPECT service:

> It is our proposition…that the tender process was a farce and not conducted in good faith; and it was never [MHS's] intention to utilise the services of Rape and Domestic Violence Services Australia to its full capacity but rather to minimise Rape and Domestic Violence Services Australia's input as much as possible without any due regard to the valuable quality service it can and does provide to those in most need.
>
> Further, if [MHS] wished to introduce a totally new model of service it would have been fair and reasonable to advise Rape and Domestic Services Australia at the beginning of the tender process and then Rape and Domestic Services Australia could have made a decision based on the assumption that there would be a likelihood of a reduction in staff and funding as to whether or not they wished to be part of that process.[12]

2.11 RDVSA was also critical of the time it was given to consider the subcontract:

> When Rape & Domestic Violence Services Australia was called to a meeting on the 10th August 2017 a completely new sub contract was provided and the organisation was asked to respond within seven days. The 65 page document contained many points of concern including that the subcontract offered a 75% cut in funding to Rape & Domestic Violence Services Australia, the provider of the world class service.[13]

2.12 The Australian Services Union NSW & ACT (ASU) expressed dismay that RDVSA as a world renowned provider of specialist trauma counselling was 'forced to decline a take-it-or-leave-it' contract from MHS for the trauma specialist counselling service.[14] The ASU considered the tender process to be damaging to the community sector:

> Since 2010 Medibank Health Solutions has not been required by the department to face an open retender for its 1800RESPECT contract, yet the

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11 Rape and Domestic Violence Services Australia, *Submission 57*, p. 39.

12 Rape and Domestic Violence Services Australia, *Submission 57*, p. 41.

13 Rape and Domestic Violence Services Australia, *Submission 57*, p. 41.

14 Ms Natalie Lang, Branch Secretary, Australian Services Union NSW & ACT (Services), *Proof Hansard,* 8 November 2017, p. 1.

nationally and internationally acknowledged world's best practice provider, RDVSA, was required at a time that happened to coincide with it speaking out publicly and prominently against a cost-saving triage model.[15]

2.13 Mr Donaldson also argued that the process was unfair, stating:

> RDVSA is a not for profit organisation. It has always been run on a very tight financial model that ensures every available cent is used towards funding of trauma counsellors providing front line support. As a result, the organisation relies on a large amount of good will to source the provision of external support in relation to legal and commercial advice.
>
> Practically, this means that there was and remains a significant power imbalance in relation to negotiations with [MHS]. As a result, any negotiations with [MHS] were never going to be fair…I am firmly of the view that there should have been an independent arbitrator appointed by the Government to handle this process.[16]

Dispute about unmet demand and performance measures

2.14 The committee heard conflicting accounts of performance measures and what critical service levels were required. DSS, MHS and RDVSA expressed differing views on performance achieved and performance required. DSS did not respond to the committee's request for quarterly and annual reports of performance by RDVSA.

2.15 As noted in Chapter 1, DSS indicated that, for the financial year 2014–15, 72 per cent of calls (37 532) to the 1800 RESPECT service were not answered. Both MHS and DSS noted that in the 2015–16 financial year, which was the last full financial year prior to the introduction of the 'First Response' model, 42 560 calls (or 67 per cent) to the 1800 Respect service went unanswered.[17]

2.16 RDVSA strongly disputed the DSS's assessment of issue of unmet demand, advising that there was an increase of demand without any commensurate increase in funding:

> During the period of time that we [RDVSA] offered the service, from 2010 to 2016, there was a 186 per cent increase in funding, and we were incredibly grateful for that…At the same time we had a 191 per cent increase in occasions of service. So we were commensurate with the funding. But the problem was there was a 234 per cent increase in demand. That's where the gap was. It's not that we weren't providing quality services or that we were sitting around filing our nails; it was that demand was much higher than capacity.[18]

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15 Ms Natalie Lang, Branch Secretary, Australian Services Union NSW & ACT (Services), *Proof Hansard,* 8 November 2017, p. 1.

16 Mr Adair Donaldson, *Submission 61*, p. 3.

17 Medibank, *Submission 29*, p. 5; Department of Social Services, *Submission 31*, p. 6.

18 Ms Karen Willis, Executive Officer, Rape and Domestic Services Australia, *Proof Hansard*, 8 November 2017, p. 13.

2.17 RDVSA asserted that, in fact, it had been answering 75 per cent of calls.[19] Ms Karen Willis, Executive Officer, RDVSA, stated that she had 'no idea' where the figure of approximately 42 000 unanswered calls for the 2015–16 financial year came from.[20] Ms Willis provided information to the committee on what RDVSA called 'occasions of services', clarifying that voicemails were not counted as occasions of service, but if someone rang and left a voicemail and was called back, the call back was an occasion of service.[21] Ms Willis outlined that this measure had been the subject of disagreement between MHS and RDVSA:

> Occasions of service are directed by our subcontract. We actually had considerable disagreement with the way the measures were counted [by MHS]. The subcontract itself actually tells us that these are the things that we have to count, and that is what we provided. That's also why when we reported we also reported on the statistics from our client file database, because that actually gave you the exact number of times we spoke with a client.[22]

2.18 In response, MHS countered:

> One of the things you mentioned was to do with the dispute in the data and the 75 per cent of calls RDVSA say were being answered. I think it is really important to note that some of their interpretation of the data is different in the fact that the way RDVSA report is on what is called an 'occasion of service'. That includes calls being answered and calls going to voicemail, emails, and also outbound calls being made. To then understand what outbound calls related to which call back or which client they were calling back, it is really impossible to kind of align…[23]

2.19 Dr Roslyn Baxter, Group Manager, Families Group, DSS, stated:

> Occasions of service are a distraction. They include voicemail responses that are responded to and they include emails. This means that seven occasions of service could represent support for just one client. We believe they are an inaccurate way of tracking how a service has responded to the needs of women calling in. The 234 per cent demand increase that was quoted this morning by RDVSA includes occasions of service as both a measure of demand and a way of meeting that demand. The department

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19 Ms Karen Willis, Executive Officer, Rape and Domestic Services Australia, *Proof Hansard*, 8 November 2017, p. 13.

20 Ms Karen Willis, Executive Officer, Rape and Domestic Services Australia, *Proof Hansard*, 8 November 2017, p. 12.

21 Ms Karen Willis, Executive Officer, Rape and Domestic Services Australia, *Proof Hansard*, 8 November 2017, p. 13.

22 Ms Karen Willis, Executive Officer, Rape and Domestic Services Australia, *Proof Hansard*, 8 November 2017, p. 13.

23 Ms Nicole McMahon, General Manager, 1800 RESPECT, Medibank, *Proof Hansard,* 8 November 2017, p. 23.

> does not measure it in that way, nor do we believe it is an appropriate way to measure responses to women's calls for a service such as this.[24]

2.20 The committee notes that the funding subcontract between MHS and RDVSA defined contacts or occasions of service (requests for and responses to counselling, information or referral on the Services made via telephone email, online and other channels) as the performance measure of critical service levels required.

2.21 A lack of agreement between DSS MHS and RDVSA on how performance is measured proved difficult to resolve as DSS failed to provide the committee with the quarterly and annual performance and critical service level reports as requested.

Accountability of DSS and MHS for the delivery of 1800 RESPECT

2.22 The committee had great difficulty in gaining access to program evaluation, and program performance details. Neither DSS nor MHS demonstrated a clear understanding of their accountability and transparency requirements to the parliament and its committees. The extent that future performance measurement assesses quality trauma counselling service as well as quantitative metrics of staffing levels and call rate is unclear.

2.23 DSS explained its role in relation to the delivery of the 1800 RESPECT service:

> DSS does not stand with a single organisation or provider in the provision of these services. We perform the role of government in examining the evidence and taking the necessary steps to ensure the best service possible. We hold MHS very strongly to account at each step because of that and we do this for the vulnerable women and others who need this service.[25]

2.24 DSS requested that the funding agreements for the delivery of the 1800 RESPECT service between itself and MHS be accepted on a confidential basis by the committee. In providing answers to questions on notice, DSS provided a copy of the current and after a significant delay, the past funding agreements.

2.25 At the public hearing, Dr Baxter sought to explain the nature of the key performance indicators (KPIs) in the agreement between DSS and MHS:

> There are measures that go to calls being answered, which, as I've identified in my opening statement, we very much consider a measure of quality. They go to amount of calls answered and speed of calls being answered, and there are KPIs which go to ensuring that call wait times are not too long. Then there are measures of quality which go to how both the first-responding element of the service and the trauma element of the service work. They relate to the qualifications that are required for counsellors who are meeting each of those elements of the service and they go to measuring the process for the delivery of the counselling around engaging with the

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

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

> client; the development of a toolkit that is sensitive to client needs; the development of therapeutic plans; how clients are referred to services; and the number of calls that are transferred to trauma specialist counselling.[26]

2.26 As to holding MHS to account for the delivery of the 1800 RESPECT service, DSS expressly stated:

> Our contract requires that those standards will be met by MHS in delivering the service and those standards will flow through to any agreement with subcontractors…There's quite a lot of detail in the contract about the quality markers that are required of the service, both the trauma specialist arm and the first responding arm of the service…The new contract also gives us levers to withhold funding if we are not satisfied…We hold MHS to account for those measures. We require qualitative and quantitative information to respond to those measures. Where they are not met, we ask for rectification and we follow up very quickly with MHS.[27]

2.27 In relation to DSS's ability to monitor the subcontract, Dr Baxter indicated:

> All of our levers are with MHS, but they do specify the requirements that we have for the service as a whole and they specify that all of those requirements must flow through to the subcontractor.[28]

2.28 In answers to questions on notice, DSS reiterated that its contractual arrangement was with MHS, and that any questions in relation to the subcontract would need to be addressed by MHS.[29] The contract provides that MHS must obtain the express consent of the subcontractor for DSS to disclose, for reporting purposes, the identity of the subcontractor, and existence and nature of the subcontract. Critically, however, the contract anticipates, and permits, the disclosure of confidential material by the parties to a House or a Committee of the Parliament.

2.29 MHS did not disclose its KPIs for MHS staff for delivery of the 1800 RESPECT service, stating that the information is confidential. As noted above, all agreements between MHS and DSS note that MHS is permitted to disclose confidential information in response to a request by a Committee of the Parliament. For the trauma specialist service MHS indicated its KPIs are:

> …around fill rate and making sure we have 96 per cent of the allocated shift hours completed across the partners, or ensuring they have an adherence to the schedule. We are making sure that we understand the percentage of time

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26 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard,* 8 November 2017, p. 37.

27 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard,* 8 November 2017, p. 38.

28 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard,* 8 November 2017, p. 38.

29 See for example, Department of Social Services, answer to questions on notice No. 7 and No. 8, received 24 November 2017

each staff member is working, and there are certain competency standards that we are holding our partners to.[30]

2.30 Ms Melissa Cranfield, Assistant Secretary, Office for Women, Department of the Prime Minister and Cabinet (PM&C) stated that the responsibility for funding, procurement, implementation and operation of the National Plan, including the 1800 RESPECT service, lies with portfolio agencies. Ms Cranfield indicated that the Office for Women had full confidence in DSS's management of the 1800 RESPECT service:

> We have full confidence in DSS's management of the 1800 RESPECT service, and the recent changes to the service delivery [First Response] model are helping to ensure that 1800 RESPECT remains a responsive and high-quality service.
>
> Please be assured that we sought and received information from DSS in relation to 1800 RESPECT on matters in which the Office for Women and the minister were interested. We were satisfied in the information we received from DSS and the assurances we were provided.[31]

Implementation conversations prior to the tender process

2.31 The ASU's submission included evidence under the heading 'Procurement and contracting issues'. The committee made a decision to accept this material *in camera* on a preliminary basis, and then to publish it after giving the parties named in the material the opportunity to comment.

2.32 The material comprised of a number of emails amongst the then board members of RDVSA; and between the board and officers from MHS and DSS. The emails cover the period from 30 November 2016 to 10 December 2016, and relate to the negotiations for the continuation of RDVSA's contract with MHS.

2.33 Taken together, the emails suggest that MHS had communicated to the former board that RDVSA's contract renewal was conditional on certain internal governance issues being resolved to MHS's satisfaction.

2.34 One then board member wrote:

> [RDVSA 1] and I just met with [MHS2] from MHS, [MHS 1] (our new contact), and [MHS 3].
>
> In words of one syllable, they said that if K does not come back to RDVSA they will forget the current revised agreement and begin talks on a new contract for July 2017 and beyond (possibly even to July 2019). They made it clear that they want RDVSA to be the subcontractor, but only if the current good relationship continues without the former EO. If K comes

30 Ms Nicole McMahon, General Manager, 1800RESPECT, Medibank, *Proof Hansard,* 8 November 2017, p. 21.

31 Ms Melissa Cranfield, Assistant Secretary, Office for Women, Department of the Prime Minister and Cabinet, *Proof Hansard,* p. 36.

> back, we can kiss any further agreement goodbye – they could not have been clearer about this.[32]

2.35 As part of considering the emails provided by ASU, the committee was provided with the extended email conversations to which the excerpts in the submission were part. The committee has decided not to release these emails, however, they do evidence the invidious position in which the then board members found themselves. There was a lengthy discussion about how to handle the situation and the committee understands that these issues played heavily on the minds of the former board members.

2.36 The committee notes that the emails do not state that DSS directed MHS to engage with RDVSA in this manner. They do, however, suggest that DSS officers may have been aware of and endorsed MHS's actions.

2.37 In responding to the ASU's submission, DSS noted:

> - [MHS] had the contractual relationship with [RDVSA];
> - MHS was therefore responsible for the subcontracting arrangements;
> - The Department was one step removed from the procurement process, and did not attempt to influence this process;
> - The relationship between MHS as the contractor and the sub-contractor must be functional, respectful and based on trust.[33]

2.38 DSS again deferred to MHS as being in the best position to respond to questions about the relationship between the contractor and the sub-contractor, and questions about conversations and negotiations which took place between the two parties.[34]

2.39 DSS indicated that the emails raised two distinct issues in relation to procurement:

- discussions around the implementation of First Response model; and
- discussions about the new sub-contract post June 2017.

2.40 In relation to the implementation of the First Response model, DSS stated:

> Several discussions took place during the period May to December 2016 between the Department, MHS and RDVSA about whether a varied

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32 Australian Services Union NSW & ACT (Services) Branch, *Submission 58*, Special Appendix, p. 6 of 13.

33 Correspondence from Ms Barbara Bennett, Deputy Secretary, Department of Social Services, to the Senate Finance and Public Administration References Committee, dated 8 December 2017, p. 1, available a response to the ASU submission, *Submission 58*.

34 Correspondence from Ms Barbara Bennett, Deputy Secretary, Department of Social Services, to the Senate Finance and Public Administration References Committee, dated 8 December 2017, p. 1, available a response to the ASU submission, *Submission 58*.

> contract between MHS and RDVSA would be required to implement the First Response Model, or whether the implementation could be managed under the existing contractual framework…These were implementation discussions rather than contractual negotiations as they did not proceed as far as the development of a draft contract variation on which to base formal negotiations. The outcome of these discussions was that the existing contract between MHS and RDVSA continued. The Department was asked to approve the decision of MHS not to negotiate a sub-contract variation for the period up until June 2017 and to enable the new model to be implemented using the existing sub-contract. The Department indicated its endorsement of that approach.[35]

2.41 On the discussion about the new sub-contract post June 2017, DSS stated:

> The formal process in respect of the new-subcontract did not commence until February 2017 and formal negotiations did not commence until March 2017.[36]

2.42 At the public hearing, Dr Baxter denied that DSS, in the course of its 'brokering role' on the implementation of the First Response model, had indicated to MHS or RDVSA that the implementation was contingent on certain personnel staying or leaving RDVSA.[37]

2.43 In responding to the ASU submission, DSS reiterated this point:

> At no time has the Department ever held or expressed a view that the subcontracting arrangements for the 1800RESPECT service were dependent on who held the role of Executive Officer of RDVSA.
>
> The Department has always valued the relationship with a not-for-profit partner and recognises the importance of having a specialist, gender-informed organisation such as RDVSA playing a critical role in the delivery of the 1800RESPECT service.[38]

2.44 Medibank also responded to the emails in the ASU's submission. Medibank stated that the accusations made by the ASU are 'inaccurate and misleading'.[39] Further:

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35 Correspondence from Ms Barbara Bennett, Deputy Secretary, Department of Social Services, to the Senate Finance and Public Administration References Committee, dated 8 December 2017, p. 2, available as a response to the ASU submission, *Submission 58*.

36 Correspondence from Ms Barbara Bennett, Deputy Secretary, Department of Social Services, to the Senate Finance and Public Administration References Committee, dated 8 December 2017, p. 3, available as a response to the ASU submission, *Submission 58*.

37 Dr Roslyn Baxter, Group Manager, Families Group, Department of Social Services, *Proof Hansard,* 8 November 2017, p. 44.

38 Correspondence from Ms Barbara Bennett, Deputy Secretary, Department of Social Services, to the Senate Finance and Public Administration References Committee, dated 8 December 2017, p. 4, available as a response to the ASU submission, *Submission 58*.

39 Medibank response to ASU Submission, p. 1, available as a response to the ASU submission, *Submission 58*.

> Medibank also notes that the ASU did not raise any of these issues with us or engage us in a dialog around these issues. Medibank met with the ASU multiple times and endeavoured to work with them in the best interests of [RDVSA] employees impacted by [RDVSA's] decision not to be part of the 1800RESPECT service going forward.[40]

2.45 Medibank disputes that the 'positive relationship fostered over the past three months' refers to the removal of the former Executive Officer of RDVSA:

> This statement does not mention the previous executive officer at all. It simply states that any continuation of the subcontracting arrangement would be contingent upon the continuation of the good, positive relationship which had recently been fostered between Medibank and [RDVSA]. A good, positive relationship is vital for the continual improvement of the service to ensure the women, children and men who use the service get the very best service possible, and to ensure that Medibank is able to comply with the conditions set out in its Funding Agreement with the DSS.[41]

Clinical governance issues

2.46 The committee does not have the capability or remit to assess clinical governance frameworks and clinical manuals. The committee noted that concerns have been raised about the delivery of the new model, the service sequencing and timing.

2.47 RDVSA considered the MHS clinical governance framework for the 1800 RESPECT service did not meet the ethical standards of professional associations to which employed counsellors belong as it appeared to focus on risk management rather than the provision of the best trauma counselling.[42]

2.48 RDVSA asserted that effective clinical governance incorporates policy, research and evidence based practice, leadership communication, collaboration, qualified workforce, training, professional development reporting, records management, quality assurance and risk management. RDVSA states:

> This cannot be done remotely, as proposed by Medibank.[43]

2.49 RDVSA stated its counselling practice is directed by the *Best Practice Manual for Specialised Sexual, Domestic and Family Violence Counselling,*

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40 Medibank response to ASU Submission, p. 1, available as a response to the ASU submission, *Submission 58.*

41 Medibank response to ASU Submission, p. 5, available as a response to the ASU submission, *Submission 58.*

42 Rape and Domestic Violence Services Australia, *Submission 57* pp. 7 and 41–42; Attachment 6, pp 1–2.

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

Version 3, 2016, as well as providing a brief exposition of matters covered by the manual.[44]

2.50 MHS has advised that it has developed its own best practice manual, review of which is ongoing and iterative. MHS advised that the manual containing details of their clinical governance framework is commercial-in-confidence.[45]

2.51 Ms Annette Gillespie, Chief Executive Officer, safe steps Family Violence Response Centre, noted that the panel providers have a clinical governance model in place, which has been agreed to by all parties:

> We have a clinical governance framework that is in place…It will be reviewed on an on-going basis, but it's what we are working to right now. But we also have guidance on trauma-informed practice, so there is a specific document providing trauma-informed practice for counsellors, and there is a clinical governance framework that sits underneath.[46]

2.52 Ms Diane Mangan, Chief Executive Office, DV Connect, suggested that the clinical manuals would be similar:

> I would imagine that a lot of it [content of manuals] would align. The models are fairly similar around the world – the practice and the acknowledgement around trauma and the response to trauma…It's not that they're doing it differently in the UK to Australia. We're generally all following the same model. We listen and learn from each other. I would say that we would imagine that, if we were dealing specifically with cases of trauma, you probably wouldn't get a better manual [than RDVSA's].[47]

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44 Rape and Domestic Violence Services Australia, *Submission 57,* pp. 7–30.

45 Dr Linda Swan, Chief Medical Officer, Medibank, *Proof Hansard,* 8 November 2017, pp. 16–20.

46 Ms Annette Gillespie, Chief Executive Officer, safe steps Family Violence Response Centre, *Proof Hansard*, 8 November 2017, p. 29.

47 Ms Diane Mangan, Chief Executive Officer, DV Connect, *Proof Hansard*, 8 November 2017, p. 31.

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

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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

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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]

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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

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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

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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.

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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:

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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]

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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

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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]

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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]

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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.

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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

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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]

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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]

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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.

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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.

Chapter 4

Committee View and Recommendations

Committee View

4.1 1800 RESPECT is a critical element in an effective response to the scourge of sexual assault and domestic and family violence. Since its establishment in 2010 the program has supported countless survivors. The effective delivery of this service remains a national priority of the highest order.

4.2 In the course of this inquiry the committee received evidence from 61 organisations and individuals. The evidence confirmed the significance of the service, and the high regard in which the service is held in the community.

4.3 None the less, some submissions have contended that recent policy and operational decisions in relation to the service establish a trajectory which in the coming years will not serve the public interest, and in particular, the interests of those who rely on the service. Other evidence has raised questions about the process by which such decisions have been made, and whether such processes are consistent with the practices and values which must underpin the delivery of public services.

4.4 The committee has sought to engage both diligently and soberly with this evidence, mindful of the imperative to ensure that those seeking assistance retain confidence in the service. Every person who needs assistance must feel confident that their first brave step will receive a professional, skilful, confidential and compassionate response.

4.5 Our conclusions and recommendations reflect our best efforts to establish a proportionate and thorough response to the evidence presented.

Delivery of counselling services

4.6 The committee notes evidence that not every caller requires a trauma specialist counselling response at the time of the call. However, the evidence provided concurred that the first responders need to have trauma expertise and work within a trauma informed counselling model, and callers requiring trauma specialist counselling must be put through to a trauma counsellor quickly.

4.7 The committee is concerned that the first response counsellors employed by MHS are less qualified and less experienced than those accepting calls under the previous model; whereas the previous arrangement required staff with a minimum training of three years' experience, present arrangements require only two. Furthermore, the funding agreement between DSS and MHS for the delivery of the first response triage service requires counsellors with broad qualifications rather than trauma-specific expertise and with two rather than three years counselling experience.

4.8 The committee notes that it is a significant challenge for the three new not-for-profit subcontractors to be required to develop a systemic capability with the appropriate level of trauma counselling skills and sufficient counsellors to be able to

ensure that both quantitative and qualitative measures can be met in respect of present and future demand. Support for this transition is a priority.

4.9 More broadly, the committee shares the concerns of the sector regarding the medium term suitability of private sector provision of these counselling services The 1800 RESPECT service and its performance measurement must reflect quality and client-focus as well as volume and efficiencies.

Recommendation 1

4.10 The committee recommends that the Government ensure that 1800 RESPECT first response triage counsellors and trauma counsellors have adequate qualifications and experience and an appropriate work environment. Specifically that:

- **The 1800 RESPECT first response triage service is staffed only by counsellors with a minimum three year tertiary degree in counselling or equivalent and a demonstrated minimum three years' experience in specialised counselling in family domestic violence and sexual assault counselling and working with clients from diverse backgrounds and locations.**
- **The committee recommends that the government review the working arrangements for first response counsellors employed by Medibank Health Solutions, and intervene to ensure that:**
    - **first responders receive appropriate initial and ongoing training;**
    - **appropriate clinical supervision is provided;**
    - **the practice of working from home cease; and**
    - **policies and procedures aimed at protecting clients, and also those aimed at protecting responders from vicarious trauma, are implemented.**
- **More broadly, the committee recommends that the government consider whether having a principal contractor, rather than the specialist services themselves, providing first responder services represents value for money and best-practice.**

Recommendation 2

4.11 In respect of the trauma specialist counsellors, the committee recommends:

- **that sufficient funding be made available for the telephone counselling function of the 1800 RESPECT to ensure that there are sufficient specialist trauma counsellors to meet current and future demand for counselling, having regard to both quantitative and qualitative performance measures.**

Transparency

Public accountability and program evaluation

4.12 The delivery of this public service by private and non-government organisations must be subject to the same level of scrutiny as programs delivered by government. The apparent lack of awareness of the legal and accountability requirements of government by executive and senior staff in the DSS and MHS is of great concern to the committee.

4.13 The committee expressed deep concerns at the lack of accountability and evaluation information for a public program. The committee observed a lack of consistency across definitions of service level and performance and that DSS, MHS and RDVSA seemed to be using different metrics and definitions of minimum service levels. These performance metrics and program evaluation are an important aspect of public accountability and effective service delivery.

4.14 The committee notes concerns from the sector that quantitative targets will receive greater attention than qualitative targets under the current funding agreement and MHS first-responder model. The committee acknowledges concerns that a for-profit model could undermine service delivery.

Procurement

4.15 The Committee expressed deep concerns that program procurements and subcontracting tender processes did not follow government procurement guidelines.

4.16 The Committee notes that the contract between MHS and the Commonwealth has not been subject to a tender process since the privatisation of MHS. The Committee further notes that the subcontracting process conducted by MHS was rushed.

4.17 The Committee is significantly disturbed by an apparent attempt by MHS and DSS to influence RDVSA internal governance and withhold a multi-million dollar contract pending staff and board changes. The committee received evidence that the subcontract with RDVSA was contingent upon the organisation's AGM result and the appointment of a new CEO.

Recommendation 3

4.18 The committee notes that many of the procurement and accountability issues revealed in this inquiry are the remit of the Australian National Audit Office (ANAO) and strongly recommends that the government management of the program and its procedures is reviewed by the ANAO.

Recommendation 4

4.19 The committee recommends that the Department of Social Services develop an evaluation schedule for the 1800 RESPECT program and release a high level evaluation plan that includes the quantitative and qualitative performance measures the contractors and sub-contractors will be measured against.

Recommendation 5

4.20 The committee recommends the Department of Social Services brief its staff and contractors on their legal and contractual requirements in program management and Senate Standing Orders.

Recommendation 6

4.21 The committee further recommends that the government consider whether the principal contractor model, as currently arranged, represents value for money and best-practice. Specifically, the committee recommends that the government consider whether the value of the contract management services provided by Medibank Health Solutions (MHS) justifies the public funding provided to MHS for that purpose, or whether that is a function that would be better provided by government, with MHS retaining responsibility for the technological (telephony and online) aspects of the program.

Privacy and confidentiality

Committee view

4.22 The committee acknowledges that trust in 1800 RESPECT by callers and potential callers is vital to the effectiveness of the service. The 1800 RESPECT service must provide clients with relevant information pertaining to the extent and limitations of privacy and confidentiality in a manner that they fully understand. Within these statements, the period of time that personal information is kept and the circumstances under which personal information would be de-identified and not destroyed must be articulated clearly.

4.23 The panel-model subcontracts between Medibank, safe steps, DV Connect and Women's Safety Services SA introduced a new requirement for calls to be recorded. The committee notes the concerns and mixed views within the counselling sector about the appropriateness of the approach, specifically that some feared that it would dissuade women from using the service.

4.24 Given the contentious nature of voice records, the committee considers it vital that appropriate protections are in place in relation to utilisation of privilege. This process appears to be driven by MHS standard practice rather than driven by client need. The committee notes that women-led organisations maintain particularly strict protocols that offer vital protections in relation to privileged information and that these protocols informed the operation of 1800 RESPECT up until the new agreements.

4.25 These protocols cover more than just the issue of confidentiality. The committee heard evidence that RDVSA used a set of guidelines that they had developed, and that were recognised as best practice for the delivery of their services. The committee believes it is important that this institutional knowledge is not lost. Instead, it should inform the delivery of services going forward irrespective of which service provider is under contract. The committee is of the view that DSS and MHS should take an active role in ensuring the transmission of valuable knowledge, and the continuity of the quality and standards that go with it.

Recommendation 7

4.26 The committee recommends that the Department of Social Services require Medibank Health Solutions to develop 1800 RESPECT specific privacy information that clearly explains how personal information will be recorded and maintained. The privacy information will detail what the individual's options are, including opting out of recordings and remaining anonymous.

Recommendation 8

4.27 The committee recommends that the Department of Social Services (DSS) require Medibank Health Solutions (MHS) to develop a clear statement for the 1800 Respect website detailing:

- **how MHS manages information, voice records and files; and**
- **relevant information on the extent and limitations of privacy and confidentiality in a manner that they potential callers can fully understand.**
- **that the DSS develop a clear, written protocol on handling of subpoenas and applying for privilege for MHS and subcontractors by March 2018.**
- **that staff are informed of these protocols and their requirements.**
- **that this protocol is made available on the 1800 RESPECT website.**

Senator Jenny McAllister

Chair

Additional comments from Government Senators

Introduction

1.1 Government Senators are pleased that the committee's report reflects a general commitment to 1800 RESPECT to better support women, children and men who require it. It is and should be the focus of government to continually improve the service. This should be done regardless of who provides the service.

1.2 Government Senators are concerned about some recommendations, particularly those in relation to the procurement process, which are not borne out by the evidence provided. As such, government senators do not agree with these recommendations.

1.3 Government Senators are also concerned by the report's heavy reliance on testimony by the ASU, which given its highly political campaign against the change in service delivery model, is not an impartial source of information.

Procurement process

1.4 Government Senators disagree with statements made within recommendations 2 and 3, specifically 4.12, 4.15 and 4.18.

1.5 Government Senators do not believe that there is sufficient evidence provided to the committee that indicates that the procurement process did not occur properly.

1.6 Consistent with subcontracting arrangements, MHS was responsible for conducting an open, transparent and competitive tender process and appointed O'Connor Marsden and Associates as the external probity advisor to oversee both the EOI and subsequent request for proposal process.[1]

1.7 MHS also appointed an evaluation panel, which included two independent subject matter experts with expertise in sexual assault, domestic and family violence.[2]

1.8 Government Senators acknowledge that there was discussion prior to the procurement taking place, as evidenced by emails provided by the ASU, and these have been comprehensively responded to by both DSS and MHS. The emails conflate issues around the new subcontract with changes to the existing contract.[3]

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1 Department of Social Services, *Submission 31*, p. 23.

2 Department of Social Services, *Submission 31*, p. 23.

3 Department of Social Services, response to ASU submission, *Submission 58*, pp 2-3 and Medibank response to ASU submission, *Submission 58*, p. 6.

Qualifications of MHS counsellors

1.9 Government Senators believe that the evidence provided by MHS and DSS is sufficient to indicate that appropriate training is provided to MHS first response counsellors prior to their commencement including two years practical experience.[4]

1.10 Government Senators have concerns that evidence provided by Mrs Emily Lachevre is included in the committee's report as it is unverifiable hearsay.

1.11 Government Senators note that there is a contractual requirement to lodge complaints and a clear process for doing so.[5] No evidence has been provided to the committee that indicates a complaint was made.

Conclusion

1.12 Government Senators are pleased that the committee report reflects a general commitment to the 1800 RESPECT service.

1.13 Government Senators are of the view that the procurement process was appropriately and properly conducted.

1.14 Government Senators are of the view that MHS first responders are appropriately qualified and that MHS has appropriate training in place.

1.15 Government Senators are encouraged that the committee has recognised that there has been a significant improvement in the service which will benefit the women, children and men who have been impacted by domestic and family violence, and sexual assault.

Senator James Paterson

Deputy Chair

4 Medibank provided the committee with a copy of the 1800 RESPECT Service Delivery Manual as a confidential document.

5 As noted in the majority report the funding agreements and subcontracts have been provided as confidential documents.

Appendix 1

Submissions and additional information received by the committee

Submissions

1	Bankstown Women's Health Centre
2	Australian Women's Health Network
3	The Hunting Ground Australia Project
4	Penrith Women's Health Centre
5	The Sydney Feminists
6	Ms Judith Shepherd-Pemell
7	Ms Paula Martin
8	Name Withheld
9	National Council of Women of South Australia
10	Psychotherapy and Counselling Federation of Australia
11	Name Withheld
12	Name Withheld
13	safe steps Family Violence Response Centre
14	Women's Legal Service NSW
15	End Rape on Campus Australia
16	Name Withheld
17	Women's Domestic Violence Court Advocacy Service NSW
18	Federation of Ethnic Communities' Councils of Australia (FECCA)
19	Red Rose Foundation
20	Women's March Sydney

21	Women's Health Tasmania
22	WILMA Women's Health Centre
23	Illawarra Women's Health Centre
24	Illawarra Forum
25	The Royal Australian and New Zealand College of Psychiatrists
26	Mr Alex Greenwich, Member for Sydney
27	Family Planning NSW
28	Central West Women's Health Centre
29	Medibank
30	Dr Ses Salmond
31	Department of Social Services
32	Women's Health NSW
33	Victorian Women's Trust
34	Fair Agenda
35	Government of South Australia, Premier's Council for Women
36	Gold Coast Centre Against Sexual Violence
37	Blue Mountains Women's Health and Resource Centre
38	Australian Council of Trade Unions
39	Gippsland Women's Health
40	Australian Women Against Violence Alliance
41	ACON
42	NSW Women's Alliance
43	Leichhardt Women's Community Health Centre
44	Unions NSW
45	Jo Haylen MP, Member for Summer Hill & Trish Doyle MP, Member for the Blue Mountains

46	Domestic Violence NSW
47	DV Connect
48	Name Withheld
49	Women's Legal Service
50	Wagga Women's Health Centre
51	Centre Against Sexual Violence
52	Mr Adrian Cooke
53	Ending Violence Against Women Queensland
54	Name Withheld
55	Ms Marisol Pacheco
56	Australian Psychological Society
57	Rape & Domestic Violence Services Australia
58	Australian Services Union NSW & ACT (Services) Branch
59	Australian Services Union (ASU) (National Office)
60	Australian Services Union Vic & Tas Branch
61	Mr Adair Donaldson

Answers to Questions taken on Notice

- Answers to questions taken on notice from Medibank Health Solutions, received 6 November 2017.
- Answers to questions taken on notice from Medibank Health Solutions, received 6 November 2017.
- Answer to questions on notice from Australian Services Union NSW & ACT (Services) Branch, received 14 November 2017, following a public hearing in Sydney on 8 November 2017.
- Answers to questions on notice from Rape and Domestic Violence Services Australia, received 15 November 2017, following a public hearing in Sydney on 8 November 2017.
- Answers to questions on notice from Medibank Health Solutions, received 15 November 2017, following a public hearing in Sydney on 8 November 2017.

- Answers to questions on notice from Department of Social Services, received 16 November 2017, following a public hearing in Sydney on 8 November 2017.
- Answer to question on notice from safe steps Family Violence Response Centre, received 20 November 2017, following a public hearing in Sydney on 8 November 2017.
- Answers to questions on notice from Department of Social Services, received 24 November 2017, following a public hearing in Sydney on 8 November 2017.
- Answer to question on notice from Department of Social Services, received 1 December 2017, following a public hearing in Sydney on 8 November 2017.

Tabled Documents

- Ms Karen Willis, Executive Officer, Rape and Domestic Violence Services Australia, 'Factsheet on funding and occasions of service', Sydney public hearing, received 8 November 2017.
- Ms Karen Willis, Executive Officer, Rape and Domestic Violence Services, 'A Best Practice Manual for Specialised Sexual, Domestic and Family Violence Counselling', Sydney public hearing, received 8 November 2017.

Appendix 2

Public hearing

Wednesday 8 November 2017
Portside Centre
207 Kent Street, Sydney NSW

Witnesses

Australian Services Union
Ms Judith Wright, Deputy Branch Secretary
Ms Natalie Lang, Branch Manager

Rape and Domestic Violence Services Australia (RDVSA)
Ms Karen Willis OAM, Executive Officer
Ms Emily Lachevre, Trauma Specialist Counsellor

Medibank Health Solutions
Ms Justine Cain, Divisional General Manager Medibank Health
Dr Linda Swan, Chief Medical Officer
Ms Nicole McMahon, 1800 RESPECT General Manager

safe steps Family Violence Response Centre
Ms Annette Gillespie, Chief Executive Officer

DV Connect
Ms Diane Mangan, Chief Executive Officer

Department of Social Services
Dr Roslyn Baxter, Group Manager, Families Group
Ms Kathryn Mandla, Principal Adviser, Families
Ms Chantelle Stratford, Branch Manager, Families

Department of the Prime Minister and Cabinet
Ms Melissa Cranfield, Assistant Secretary, Office for Women