Submission to the Victorian Law Reform Commission

Legal Privilege and Integrated Legal Assistance Services: Consultation Paper

Prepared for VAADA by
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Acknowledgement of Country

VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.

About VAADA

The Victorian Alcohol and Drug Association (VAADA) is the peak body representing alcohol and other drug (AOD) services across Victoria.
VAADA strengthens, champions and amplifies the voice of AOD services, advocating for policy, funding and system improvement. We work with members, government, and cross-sector partners to improve access to high-quality, person-centred AOD care.
Our vision is that everyone in Victoria has equitable access to a quality AOD system of care, when, where and how they want it.
VAADA is committed to collaboration, evidence-informed practice, Aboriginal self-determination and ensuring lived and living experience informs policy, practice and sector development.

We work to achieve this by:

- Advocating for accessible, person-centred AOD services
- Influencing policy, funding and system reform
- Supporting a capable, connected and sustainable AOD workforce
- Bringing together members, stakeholders and partners to strengthen collaboration across the health and human services sectors
- Promoting evidence-informed policy and practice
- Amplifying the voices of people, families and communities with lived and living experience
- Supporting Aboriginal self-determination through partnerships with Aboriginal Community Controlled Organisations and Aboriginal-led approaches

VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

Contents

We welcome the opportunity to respond to the Victorian Law Reform Commission's (the Commission) consultation paper on legal privilege and integrated legal assistance services.1 The questions the Commission has posed sit at the centre of daily practice for many of our members, whose clients frequently hold legal problems and health needs and who are supported by services that are, to varying degrees, integrated with legal assistance.

How this submission was prepared

This submission has been informed through a consultation process with VAADA members, most of whom are allied health practitioners working directly at the intersection with legal services. It draws on a roundtable convened specifically to consider the consultation paper, and a series of individual interviews with senior practitioners working across AOD treatment, family violence, and co-located legal and health services. Participants work in a range of service models described in the consultation paper, from cooperative arrangements with visiting legal services through to loosely integrated and closely integrated models with embedded staff.

In keeping with the Commission's practice of publishing submissions, and allowing participants to speak candidly, the views of individual contributors and their organisations have been de-identified. Where a particular perspective is attributed, it is described by sector role or service model rather than by name. The value of these contributions lies in the diversity of experience they represent. As will be clear, our members do not speak with one voice on the Commission's reform options, and we have not sought to manufacture a consensus. We have instead tried to give the Commission an accurate picture of where the AOD sector agrees, where it differs, and why there is no one neat 'fix' to the issues identified by the Commission.

Summary of VAADA's position

VAADA offers qualified support for reform of client information being better protected when legal assistance is delivered alongside social services, on a safety-first basis. In summary:

- **We agree that there is a genuine problem, but that it is narrower and more particular than the consultation paper implies.** The most acute and recurring harm our members identify is the subpoena and disclosure of AOD treatment and counselling records in ways that expose clients to

[1] Victorian Law Reform Commission, Legal Privilege and Integrated Legal Assistance Services: Consultation Paper (2026). All references to the "consultation paper" in this submission are to this document.

stigma and prejudice and deter people from seeking help. This dilemma is where reform is most needed. .

- **We support stronger protection for confidential communications with AOD and other social service professionals,** through a social service professional privilege(Option 1) rather than through extending legal privilege itself.
- **Any protection must contain a robust, MARAM-aligned safety exception** and must not weaken the family violence information sharing reforms introduced after the 2016 Royal Commission into Family Violence. Protecting the privacy of a person's health information cannot come at the cost of the safety of victim survivors and children.
- **Reform must be matched by investment in training, clear practice guidance and system capability across both legal and social service sectors,** or it will shift risk onto individual workers and the clients least able to carry it.

The legal framework as members encounters it

It may assist the Commission to record how the relevant law is experienced from inside an AOD service, which provides a different vantage point to that of a lawyer. Legal privilege protects confidential communications between a client and their lawyer made for the primary purpose of obtaining legal advice or for litigation. In integrated settings both requirements are weakened, since communication happens in the presence of, or are recorded by, non-lawyers, with the information serving several purposes at once. Our members understand this in practice, summarising the dilemma that a joint conversation about safety, housing, health and a legal remedy is not easily carved into privileged and unprivileged parts.

Critically, the protection is applied across a wide and intersecting range of legal settings and circumstances. The common law mostly governs disclosure to investigative bodies such as child protection, while the Evidence Act mostly governs disclosure to courts and other adjudicative bodies.[2] AOD and other social service professionals sit outside legal privilege altogether. Their conduct is governed instead by health privacy law, by professional and organisational confidentiality, by mandatory reporting duties where applicable, and, in the family violence context, by the Family Violence Information Sharing Scheme and MARAM. Any reform will need to recognise the vast and varied nature of AOD

[2] Consultation paper, above n 1, para 1.17, noting that the common law mostly applies to investigative bodies whereas legislation mostly applies to court proceedings and associated preliminary processes.

work and professional obligations, and its success will depend on how neatly it fits alongside existing obligations rather than cutting across them.

The AOD sector context

Three features of the AOD operating environment shape our response and should inform the Commission's thinking.

Stigma and the weaponising of treatment records

AOD treatment records carry a particular danger when they enter legal proceedings. Information showing that a person has sought treatment for substance use – evidence that should reflect responsibility, help-seeking and recovery – can be used against the individual, most sharply in child protection and family law matters. Members describe substance use history being deployed to question a parent's fitness to parent, to resist the return of children, and to undermine a party's credibility. This prejudice is amplified for First Nations families, for whom the recording of substance use significantly raises the likelihood of child removal. One consequence, reported consistently across our consultations, is that AOD workers already write less than they safely could due to the fear of harmful ramifications for their clients and because most practitioners have been involved in, or aware of, information being weaponised in past contexts. Practitioners omit or minimise potentially contentious information in case notes precisely because they fear it will be subpoenaed and misused. This is a poor outcome for everyone. It degrades the clinical record, undermines continuity of care, and still does not fully protect the client.

Stigma is not incidental to AOD care - it is one of the primary barriers to help-seeking that the sector works to overcome.[3] Fear that engaging with a service will generate a record that later resurfaces in court is a rationale to avoid or delay treatment. Any reform that reduces that fear, would advance both access to justice and public health.

Demand, complexity and workforce pressure

The sector is responding to unprecedented demand alongside rising client complexity. Agency wait lists in Victoria rose from 2,385 in 2020 to 5,122 in 2026, an increase of 115 per cent,[4] and research indicates that only 30 to 40 per cent of people who need AOD treatment in Australia receive it.[5] Co-occurring issues

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[3] R Sutherland et al, Experiences of Stigma While Visiting Healthcare Services Among People Who Use Drugs in Australia, 2022 (UNSW, Drug Trends, 2023).

[4] VAADA, Treatment Bottleneck: Record Demand, Longer Waits (2026).

[5] A Ritter and K O'Reilly, 'Unmet Treatment Demand: The Size of the Gap for Alcohol and Other Drugs in Australia' (2025) Drug and Alcohol Review 1.

including family violence, mental illness and homelessness are now the norm rather than the exception among people presenting for treatment.[6] This is relevant to the Commission's inquiry for two reasons. First, it is the reason service integration is growing: services see the benefit in combining what clients are offered to meet complex needs. Second, it is why any new obligation must be resourced. A workforce already under strain, with almost one in three workers frequently considering leaving,[7] would not be able to absorb complex new privilege and disclosure judgements without training and support.

A workforce whose duty of care is to people

A theme raised repeatedly and put most forcefully by a member agency with a long-established co-located health justice partnership, is that AOD and allied health workers are not lawyers and are not trained to think like them. As that member observed, a lawyer's primary duty is to the administration of justice and to the client's legal interests, while a health or support worker's primary duty of care is to the wellbeing of the person in front of them and, in the family violence context, to the safety of others as well. The same words - i.e. duty of care, confidentiality, file note - carry different meanings in each profession. This difference is not a defect to be legislated away by treating support workers as though they were lawyers. It is a strength of integrated practice that must be preserved. It also explains why extending legal privilege to social service professionals (Option 2), provokes a sense of legitimate unease in the sector.

Is there a problem to be solved?

Before turning to the specific questions, it is worth addressing the premise of the inquiry. When we asked practitioners whether there is a problem that needs solving, the answers ranged from "clearly yes" to "yes, but not the one the paper describes".

The consultation paper frames the problem through the experience of clients like 'Tania', whose integrated support for family violence, housing and health also exposes her private disclosures to later use against her, so that she effectively trades away legal privilege in exchange for the help she needs.[8] Members recognised this dilemma. They also recognised the principles that the paper identifies, that is, the requirements that a privileged communication that is confidential and made for the primary purpose of obtaining legal advice is

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[6] VAADA, Building Bridges: Opportunities for AOD Sector Collaboration to Enhance Outcomes for People with Co-occurring Mental Health and AOD Needs (2025).

[7] VAADA, 2025 AOD Workforce Survey Report (2025).

[8] Consultation paper, above n 1, Scenario 1 (Tania), illustrating the difficulty of establishing that communications in an integrated setting were confidential and made for the dominant purpose of obtaining legal advice.

genuinely hard to satisfy when several professionals are in the room for several purposes at once.[9]

A note of scepticism came from an experienced practitioner in a long-established co-located service, who cautioned against overstating the scale of the problem. In that practitioner's experience, where professionals genuinely understand their own and each other's scope of practice, most friction is manageable without legislative change, and the difficulty is often presented as larger and more obstructive than it is in practice. That view was offered with humility, and with the acknowledgement that practitioners in the family violence space, where the stakes are highest, may reasonably see it differently. We highlight this not to dismiss the problem but because it is a useful alternative perspective to that put forward by the Commission - the answer to a narrow, specific harm should be a targeted reform, not a sweeping change that carries its own risks.

Weighing these views, VAADA's conclusion is that there is a real problem, but that the core issue is not the incompatibility of service integration and privilege, rather, it is the recurring experience of AOD treatment and counselling records being subpoenaed and used against a client, most often in child protection, criminal, and family law. Our members highlighted this as a key harm that the AOD sector encounters all too often and should therefore be the harm against which any law reform should be measured.

Responses to the consultation questions

The Commission invited responses to seven questions. Consistent with the Commission's guidance that submissions need not follow a set format and may address some or all questions, we have concentrated on where the AOD sector has the most to contribute.

Question 1: How easy or difficult is it to implement the loosely integrated and closely integrated models in practice?

Member experience spans the full spectrum of models the consultation paper describes, from cooperative arrangements with a lawyer visiting an AOD service one afternoon a week, through to closely integrated teams sitting a few metres apart within the same organisation.[10] Our members' collective view is that neither model is especially hard to set up as a matter of logistics. What is hard is sustaining the disciplined understanding of professional roles that makes integration safe.

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[9] The dominant purpose test derives from Esso Australia Resources Ltd v Commissioner of Taxation (1999) 201 CLR 49, replacing the earlier sole purpose test in Grant v Downs (1976) 135 CLR 674.

[10] The consultation paper sets out five models: independent, cooperative, loosely integrated and closely integrated, with integration and risk to privilege increasing across the spectrum. See consultation paper, above n 1.

Input from one of our members described the single most important enabler as time spent building a shared understanding of each profession's scope of practice and obligations. In that service, legal privilege was explained to health staff by the legal team, shared terminology was actively interrogated, and the question "what don't we know about each other" was revisited as staff turned over. Where this investment is made, the practical friction of integration largely resolves itself, however, where it is not, problems arise not from the model but from misunderstandings in practice.

Members also pointed to therapeutic court and secondary-consultation settings as instructive. In venues such as the assessment and referral court list (the 'ARC' list run out of the Magistrates' Court of Victoria), professionals with different information barriers already sit around one table, and AOD practitioners sometimes choose what to contribute so as not to expose a client to harm, for example by leaving certain material out of feedback to the court, particularly where there is no relevance to the matter, as determined by the good clinical judgement. This is a considered clinical and ethical judgement which sits within the bounds of legal, professional, and ethical obligations, and it works because the professionals understand their respective roles. It illustrates a broader point our members made: what makes integration succeed is cultural and relational, rather than statutory, and reform should support that culture rather than assume a legal rule can replace it.

The loosely integrated model attracts a specific, practical concern raised by a family violence and AOD practitioner: even where files are formally separated, information leaks between services anyway, through shared meetings, warm referrals and common client-management systems – in other words, strict information barriers are easier to design than to maintain in a busy service. This is directly relevant to the Commission's reasoning, because the protection the loosely integrated model is assumed to give legal privilege depends on information barriers holding. The closely integrated model raises other issues in that much of what is discussed jointly is about safety and support rather than legal advice, and it is unclear that any of it is protected at all.

Question 2: What are the benefits of integrated legal assistance services? Do you have case studies, examples or other evidence?

Our members are strong supporters of integration and see its benefits daily. A youth-focused service described how having a lawyer within the organisation led to markedly better outcomes, because the lawyer understood the client group and could act proactively rather than waiting for a formal referral. A service running community legal and justice programs alongside AOD treatment noted that in criminal matters it is often directly to the client's advantage to be linked to AOD support, and that confidential information sharing in that context helps

rather than harms. Others described the value of warm referral and co-location in reaching clients who would never independently seek legal help.

The central benefit is that clients do not have to tell their story repeatedly to disconnected services, which is both more effective and, for people who have experienced trauma and family violence, considerably kinder. Integration also allows the legal and health dimensions of a problem to be addressed together, so that, for example, timely access to AOD treatment can support a person's position in a legal matter rather than being segregated from it. These benefits are well documented in evaluations of integrated and health justice models and are consistent with the evidence reviewed in Chapter 3 of the consultation paper. As the Australian Institute of Criminology points out, the system-level return on investment is significant too, in that every dollar invested in AOD treatment returns an estimated $5.40,[11] and integration relieves pressure on the costlier parts of the service system, including hospitals, courts and prisons.

Members also emphasised that integration is a two-way capacity-building opportunity, and that the current knowledge deficit runs in both directions. Just as AOD workers have had to learn what legal privilege means, legal professionals, and in some cases magistrates and other judicial officers, often lack a working understanding of substance use, dependence and the social determinants of health. Several members saw a responsibility, and an appetite, to provide AOD education to legal and other services, subject to capacity and funding, precisely so that treatment information is understood in context rather than as a mark against a client. This point serves as an important consideration to the reform question in that better cross-sector understanding would reduce some of the misuse of AOD records that a privilege is being asked to prevent.

A note of caution accompanies these benefits, which goes to the heart of this inquiry. The same integration that concentrates support also concentrates information. When services join up, everything about a person can end up in one place. That is helpful for coordinated care, but it means that if a single file is later pulled into court, it may contain everything, including drug use, mental health history or any other stigmatising health concern, any of which can be used against a client. Integration therefore increases both the benefit to the client and the exposure of the client. This is a tension that any reform would need to be mindful to resolve rather than exacerbate.

Question 3: Do you have case studies, examples or evidence about how easy or difficult it is to manage information disclosure requirements in this context?

[11] A Voce and T Sullivan, *What Are the Monetary Returns of Investing in Programs That Reduce Demand for Illicit Drugs?* (Australian Institute of Criminology, 2022).

The consultation paper's Case Study 4, in which a violent former partner subpoenaed the records of a loosely integrated service, was painfully familiar to our members.[12] It captures the core problem precisely - the counselling records, which contained exactly the kind of sensitive personal disclosure that AOD and family violence clients make, were ordered to be produced, while the legal records were protected. The asymmetry is stark. The support relationship that is often the precondition to a person's safety attracts the weakest legal protection.

Child protection is the area members identify as being particularly problematic. As one practitioner put it, in many legal matters a service can share selectively, but child protection systems can access almost everything. Members described developing defensive practices in response, including writing less, holding sensitive material in separate teams or systems rather than the main client record, and, in one service, actively pushing back on poorly defined child protection subpoenas by lodging objections and requesting clarification of the forensic purpose of the request. These are all legitimate and pragmatic adaptations by a sector trying to protect its clients within the existing law. They are also evidence that the current settings are not working, given workers should not have to choose between a complete clinical record and their client's protection.

A further complication is the handling of privileged or sensitive information inside an organisation, not only at the point of a subpoena. Members described the difficulty of managing information barriers during supervision, case handovers, and reporting into allied health and client-management systems, where privileged material can be inadvertently exposed. One service manages this by routing sensitive material through a separate, specialist team rather than the general client record, and members raised the value of clear internal protocols for marking and, where appropriate, redacting legally privileged information in client files. These are practical, day-to-day pressure points that any reform, and any accompanying practice guidance, will need to address.

Members also stressed that reporting and information sharing duties do not disappear because a lawyer is involved, and that this is not always explained clearly to clients. Under the family violence information sharing framework, MARAM often directs workers to share information in high-risk cases, which can pull against confidentiality with no clear rule about which prevails.[13] Managing

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[12] Consultation paper, above n 1, Case Study 4 (Anh and Lee), where the counselling records were held not to be covered by the qualified confidential communications privilege and were ordered to be produced, while the separate legal records were protected by legal privilege.

[13] Family Violence Information Sharing Scheme, established under Part 5A of the *Family Violence Protection Act 2008* (Vic), and the Multi-Agency Risk Assessment and Management (MARAM) Framework. These schemes were introduced following the Royal Commission into Family Violence (Victorian Government, 'Report', 2016).

disclosure in integrated settings is therefore not a single problem but several overlapping ones, including subpoenas, mandatory reporting, discretionary risk-based sharing, and internal information barriers, all of which are governed by a different rule.

Question 4: Should the law enhance protection for communications between clients, lawyers and social service professionals in these settings? Why or why not?

On balance VAADA supports enhanced protection, however, the case for it is strongest and least contentious when it is framed around protecting clients from the misuse of their sensitive health information, rather than around perfecting the mechanics of integration.

The strongest argument for reform comes from recent experience with counselling records more broadly. The release of the records of sexual assault survivors held by services such as 1800RESPECT, and their use by perpetrators' lawyers, prompted a public campaign to keep counselling records private,[14] and calls to upgrade the sexual assault communications privilege from a qualified to an absolute privilege. The same logic applies to AOD counselling in that accessing these records can fundamentally undermine the therapeutic work and discourage people from seeking help when they most need it. A practitioner working across family violence and AOD identified this example as the clearest reason that talking to a support service, not only to a lawyer, should attract stronger legal protection.

A countervailing view was sharpened by a specific, serious concern about misidentification. Practitioners working in family violence report that a substantial proportion of people processed through the system as using violence are in fact misidentified victim survivors, and that people who use substances, people from culturally and linguistically diverse backgrounds, and people with disability are over-represented among them. Where the system has already mislabelled a victim survivor as a perpetrator, a strong privilege attaching to that person's support records could entrench the error and shield information that services and courts need in order to correct it. This is a powerful argument that a privilege must never operate to protect a person who uses violence at the expense of the person they have harmed, and that a safety exception must be designed with the misidentification problem squarely in view.

We urge the Commission to give weight to the countervailing view. A family violence specialist within the AOD sector argued against broad enhancement on the ground that it risks unwinding hard-won reform. The family violence

[14] R Burgin and G Hamilton, 'Rapists' Lawyers Are Using Their Victim-Survivors' Counselling Notes in Court. This Needs to Stop', *The Conversation* (30 March 2026).

information sharing scheme was created because the inability of services to share information contributed to the deaths of women and children. The reforms deliberately shifted the balance so that services could see the whole context of a person's life and act on risk. Extending strong protection to social service communications, if done without care, could reconstruct exactly the barriers those reforms removed. From this view the paramount duty of a social service is to community safety, not to the privacy of the individual in front of the worker, particularly where that individual may be a person who uses violence. This was not a marginal objection but a serious warning that any reform must answer, and it is the main reason VAADA highlights the importance of a safety exception as a non-negotiable feature for any model of reform.

Question 5: Are you in favour of establishing (a) a social service professional privilege for loosely integrated settings, and/or (b) a new category of legal privilege for closely integrated settings? Why or why not?

VAADA favours Option (a), a qualified social service professional privilege, over Option (b), and does so with the safety exception described under Question 6 built in.

The case for a social service professional privilege (Option a)

A stand-alone privilege attaching to confidential communications with social service professionals has three attractions for the AOD sector. First, it directly targets the potential for genuine harm (i.e. the exposure of treatment and counselling records) without requiring a lawyer to be present. As a family violence and AOD practitioner observed, much of the important work, safety planning, AOD support and case coordination, happens without a lawyer in the room. Second, a qualified privilege, of the kind that already exists for journalists and for sexual assault communications, can be overridden by a court weighing competing interests, which preserves the flexibility members value when a genuine safety issue arises.[15] Third, it sits alongside legal privilege rather than altering it, which avoids the conceptual and workforce problems created by treating support workers as quasi-lawyers.

The case against a new category of legal privilege (Option b)

Option (b) attracted the strongest reservations. Extending legal privilege itself to communications between clients, lawyers and social service professionals would impose onto health and social service practice a framework designed for a different duty. A member practitioner from a co-located partnership captured this discomfort via the following: legal privilege allows a professional to hold dangerous knowledge and do nothing, because the lawyer's duty runs to the law.

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[15] Qualified professional privileges already operate in Victoria, including journalist privilege under the *Evidence Act 2008* (Vic) s 126K, and the confidential communications (sexual assault) privilege under the *Evidence (Miscellaneous Provisions) Act 1958* (Vic) ss 32B-32G.

For an AOD or mental health worker whose entire professional identity is built on acting to keep people safe and well, a framework that says "you may simply know this and move on" is not just uncomfortable, it is contrary to the ethical basis of the work. There is also a real risk to the therapeutic relationship. If clients came to believe they could disclose anything without consequence so long as a lawyer was involved, that would undermine the honesty and accountability that treatment and recovery depends on. And because an absolute legal privilege would displace reporting and information sharing duties,[16] Option (b) poses the sharpest threat to the family violence reforms, which is why the family violence practitioners who we consulted opposed it most strongly.

For these reasons VAADA prefers Option (a). We do not, however, support Option (a) in an unqualified form. Without the safeguards below, even a social service professional privilege could be misused, and a minority of members interviewed would not support any new privilege at all, on the view that the current problem is real but narrow and is better addressed through practice, culture and the disciplined use of existing health privacy protections than through a new privilege.

Question 6: If you support a social service professional privilege, do you have a view on its scope, elements, eligibility or implications?

Our members' experience points to the following design features:

- **A qualified - not absolute - privilege.** The privilege should be capable of being overridden by a court balancing the harm of disclosure against the interest in the evidence, consistent with other Victorian professional privileges. Members valued this flexibility because it preserves the ability to act on risk. We note the counterargument that qualified privileges are uncertain and were not upheld in Case Study 4, and we accept there is a live question about whether counselling records of victim survivors specifically warrant stronger protection. On balance, for the AOD sector, a qualified privilege strikes the better balance.
- **A mandatory, MARAM-aligned safety exception.** This is the single most important element our members identified. The exception should be based on a structured risk assessment such as MARAM rather than an individual's intuition; it should extend to risk to children and to other people, not only to the client; and it should connect clearly with existing mandatory reporting and information sharing duties so that a worker is not left trying to reconcile three different rules in an emergency. The exception must be capable of protecting a victim survivor even where the person seeking to rely on the privilege is a person who uses violence.

[16] Consultation paper, above n 1, notes at para 7.46 that a new legal privilege would displace the reporting and information sharing obligations of social service professionals discussed in Chapter 4.

- **Protection against tactical misuse.** The scheme must be tested against the scenario in which a perpetrator's lawyer invokes a "safety" rationale to force disclosure of a victim survivor's file, for example by characterising drug use or a past charge as a safety concern. Any safety exception drafted only with the good-faith case in mind, can be turned against the people it is meant to protect.
- **Differentiation by client role.** Members noted that the protections appropriate to a service supporting a victim survivor may differ from those appropriate to a service working with a person using violence, because the safety risks differ. The design should be sensitive to this distinction rather than applying a single rule regardless of context.
- **A definition of covered services that includes AOD treatment and counselling.** The privilege should clearly cover government-funded AOD services and the counselling and support functions integrated with legal assistance, drawing on the professional, confidential relationship privilege as a starting point for identifying eligible professionals.
- **Attention to unequal capacity.** Larger, well-resourced services will implement information barriers, redaction protocols and privilege claims more easily than smaller AOD services. Without support, the benefit of any privilege will flow disproportionately to clients who already reach better-resourced services. Implementation must be accompanied by funded training and practice guidance for the whole sector.

Members also flagged that existing mechanisms should not be overlooked. Health privacy law, internal information barriers, disciplined case-noting, IT-based access controls of the kind used in prescription monitoring systems, and organisations' existing rights to object to disclosure, all currently provide partial protection. Several members felt the bigger problem is that these existing tools are poorly understood and inconsistently used. A new privilege should better complement use of these mechanisms, not substitute for them.

Question 7: If you support a new category of legal privilege for closely integrated settings, do you have a view on its scope, elements, eligibility or implications?

As set out above, VAADA does not favour Option (b) as its primary recommendation. We nonetheless offer the following observations should the Commission pursue it, and to assist with the specific matters on which it has sought views, i.e. the definition of closely integrated services, eligibility, a safety exception, and the implications for social service professionals.

- **The safety exception in this option is particularly critical.** Because a new legal privilege would be more likely to be absolute and would displace reporting and information sharing duties, an absolute privilege without a strong, MARAM-based safety exception would be unacceptable to the AOD and family violence sectors. The Commission's reference to the imminent-

risk-of-serious-harm threshold used for legal professionals in some jurisdictions sets the bar too high for social service practice, where duties are triggered at a lower and more protective threshold.

- **Eligibility through accreditation is preferable over case-by-case litigation.** If a new privilege is created, an opt-in accreditation model that identifies eligible integrated services in advance would provide far more certainty than leaving the question to be resolved in costly litigation after the fact. It would also let services build compliant practices deliberately.
- **Implications for the workforce must be resourced.** Placing legal-privilege judgements on health and support workers who are not legally trained, and who are already stretched, would be unworkable without substantial training, supervision and legal back-up. The privilege would otherwise shift risk onto individual workers.
- **Jurisdictional limits should be made explicit to clients.** A Victorian privilege would apply in Victorian courts but not automatically in other states or in federal courts. Much of the pressure to disclose AOD and counselling records comes from family law proceedings, which are federal.[17] A service near a state border providing integrated AOD and legal support could not safely rely on the privilege for a client charged interstate. Clients must not be given false assurance about protection that may evaporate once a matter crosses a jurisdictional line. National consistency would be the ideal end point.

[17] The consultation paper discusses at paras 7.63-7.66 whether a Victorian privilege could be "picked up" and applied in federal proceedings heard in Victoria under s 79 of the *Judiciary Act 1903* (Cth): see Rizeq v Western Australia (2017) 262 CLR 1.

Conclusion and recommendations

In seeking submissions on the question of legal privilege and integrated legal assistance services, the Commission has correctly identified a fundamental tension within the AOD sector: confidential treatment and counselling records are outside the protection of legal professional privilege. This can deter help-seeking and undermine recovery, as is currently the case in child protection and family law proceedings. Integration alone does not resolve this problem. Reform should be targeted at remedying this tension wherever possible to ensure greater access to treatment and support services, rather than further enhancing barriers to services.

It is important to reiterate that VAADA's members who were consulted for this submission do not hold homogenous views. Some see a pressing need for stronger protection; others fear that any new privilege will unwind the family violence information sharing reforms that save lives; others again believe the problem, while real, is narrower than the consultation paper suggests and is best met through better practice and the disciplined use of existing protections. These describe the real conditions in which any reform will have to work. A reform that ignores the family violence sector's warning will cause harm; a reform that ignores the treatment sector's experience of stigma will miss its purpose.

VAADA therefore recommends:

1. That the Commission pursue enhanced protection for confidential communications with AOD and other social service professionals, preferably through a qualified social service professional privilege (Option 1) rather than through extending legal privilege itself (Option 2).

2. That any such privilege contain a mandatory, MARAM-aligned safety exception covering risk to children and third parties, expressly connected to existing mandatory reporting and information sharing duties, and drafted to withstand tactical misuse by a person who uses violence or their representative.

3. That reform preserve, and not diminish, the family violence information sharing scheme and MARAM, originally introduced following the Royal Commission into Family Violence.

4. That any new protection be differentiated according to whether a service supports a victim survivor or a person using violence, recognising the different safety risks involved.

5. That implementation be accompanied by funded, sector-wide training, practice guidance and legal support, with particular attention to smaller AOD services, so that reform does not shift risk onto individual workers or benefit only clients of well-resourced services.

6. That the Commission address the AOD-specific dimension of this problem directly, recognising that the stigmatisation of substance use, and the use of

treatment records against clients, is a distinct harm that reform should explicitly seek to address.

7. That, given the federal dimension of much family law litigation, the Victorian Government pursue national consistency so that clients are not left with protection that fails at the border.

Finally, VAADA urges the Commission to hold that law reform can remove a specific injustice – i.e. the routine exposure of people who have done the responsible thing by seeking treatment but that it cannot, on its own, deliver the cultural competence, resourcing and cross-sector understanding that make integration safe. The most protective thing for a client is often not a privilege claimed after the fact, but a workforce that understands its obligations, records information wisely, and shares it when safety requires. Whatever reform the Commission recommends will therefore be only as good as the investment in training, guidance and system capability that accompanies it. That investment sits alongside the wider case VAADA continues to make for a properly funded AOD system, because the same underfunding that lengthens treatment wait lists also leaves services without the capacity to manage complex legal and privacy obligations well.

VAADA would welcome the opportunity to consult further with the Commission, including to connect it with members who can speak in more detail to the practical operation of integrated AOD and legal services, and to the experiences of clients whose treatment records have been drawn into legal proceedings. We thank the Commission for undertaking this important inquiry.