41ST PARLIAMENT

Education and Health Standing Committee

Report 4

Report of the Inquiry into the Esther Foundation and unregulated private health facilities

Presented by
Mr C.J. Tallentire, MLA

December 2022

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Published and printed by the authority of the Education and Health Standing Committee of the Legislative Assembly of Western Australia.
December 2022
ISBN: 978-1-922759-10-8

(Series: Western Australia. Parliament. Legislative Assembly. Committees. Education and Health Standing Committee. Report 4)

328.365

Education and Health Standing Committee

Report of the inquiry into the Esther Foundation and unregulated private health facilities

Report No. 4

Presented by

Mr C.J. Tallentire, MLA

Laid on the Table of the Legislative Assembly on 1 December 2022

Inquiry Terms of Reference

The Legislative Assembly requests the Education and Health Standing Committee inquire into and report by 1 December 2022 on:

1. Complaints and allegations concerning the Esther Foundation including from former residents, staff and volunteers

2. Adequacy of actions taken by the organisation to address the above concerns

3. Current regulatory and legislative provisions, and those proposed provisions currently before the Parliament, to address the above concerns, including;

    a. Options for regulating facilities not covered by the definition of 'Health Service' or 'Hospital' in the *Private Hospitals and Health Services Act 1927*.

Chair's Foreword

The report of the inquiry into the Esther Foundation and unregulated private health facilities is the second inquiry by the Education and Health Standing Committee in the 41st Parliament. The inquiry and its terms of reference were referred to the Committee by the Legislative Assembly in April 2022.

The inquiry has been conducted in a spirit of looking forward. We took evidence to assess the current regulatory failings relating to facilities that are not covered by existing legislative definitions or frameworks. The Committee's aim has been to provide recommendations to Government so that vulnerable people can access the help they need without the risk of unprofessional or unqualified operators making promises they can't deliver on or causing them further harm.

Many witnesses who had been involved with the Esther Foundation expressed feelings ranging from disappointment to betrayal, from sadness to anger. They entered the Esther Foundation when they were in a state of extreme vulnerability and many reported leaving with more problems than they went in with. The Committee was very clear that we were not investigating criminal behaviour and that any matters of a criminal nature should be reported to WA Police. However, these witnesses recognised that by sharing their negative experiences, there was an opportunity to drive changes to prevent others from having similar experiences in the future.

Systems for regulating registered healthcare workers are well established. Regulating unregistered workers and institutions is more complex but, from the findings of our inquiry, very much needed. While there are many benefits to offering holistic and innovative services to meet people's diverse and complex needs, regulatory systems need to be modernised to be able to keep pace with these emerging trends. New approaches need to always be evidence-based.

There have also been long-standing calls within the AOD treatment sector to regulate private services to ensure accountability and there is an opportunity now for action to take place to progress this. Self-regulatory models are not enough to safeguard vulnerable people. Expert consultant Professor Nicole Lee highlighted that the findings and recommendations of this inquiry have implications beyond the Esther Foundation and Western Australia, because these are problems that are experienced nationally. Western Australia has a chance to be a leader in this regard.

We recognise there are other facilities in Western Australia that are operating with a similar absence of external oversight. Some are small and attached to other organisations. Future regulation needs to cover all such centres, including those that receive no government funding.

This has been a difficult and, at times, emotionally draining inquiry. Working to a tight timeline, while seeking to accommodate witnesses in a way that is fair to them, has added to the challenge of carrying out our deliberations. The outstanding quality of work by the

Committee's principal research officer Catie Parsons and research officer Sylvia Wolf has made it all possible. I am very appreciative of the work of my fellow Committee members, Deputy Chair Ms Lisa Baker MLA, Mrs Lisa Munday MLA, Ms Caitlin Collins MLA, Mr Kevin Michel MLA, and co-opted member Mr Stuart Aubrey MLA (from 16 June 2022).

Finally, I acknowledge the sincerity with which all participants to this inquiry have contributed and trust that Western Australia can soon have the necessary regulation in place across all health services.

MR C.J. TALLENTIRE, MLA
CHAIR

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Executive Summary

The Esther Foundation was a residential rehabilitation facility that operated from the early 2000s to 2022. In early 2022, allegations of abuse and inappropriate behaviours at the Esther Foundation were reported in the media and to the Minister for Child Protection; Women's Interests; and Community Services. On 7 April 2022, the Legislative Assembly referred this inquiry to the Education and Health Standing Committee to hear from affected former residents and investigate regulatory improvements that could prevent a recurrence of these kinds of events in similar institutions.

In order to determine why existing legislative and regulatory frameworks had failed to capture the Esther Foundation, it was necessary to consider what kind of organisation the Esther Foundation was. Stakeholders in the mental health and alcohol and other drug (AOD) treatment sector identified that the nature of services provided by the Esther Foundation was unclear and blurred. However, over the duration of its operations, it consistently promoted itself as providing a broad range of health and other services, including AOD treatment and mental health services.

Complaints and allegations against the Esther Foundation

The Committee received a broad range of complaints and allegations regarding the Esther Foundation spanning a period from 2004 to 2020. Some of the prevalent and consistent themes that emerged from the complaints and allegations included emotional and psychological abuse, coercive and extreme religious practices, LGBTQA+ suppression and conversion practices, culturally harmful practices, medical complaints, family alienation, physical restraints and assaults, and sexual assault.

The inquiry also received some evidence from former residents, staff and volunteers in support of the Esther Foundation.

Although the Committee is not in a position to investigate individual incidents, we found that unacceptable practices occurred at the Esther Foundation which caused harm to residents, staff, volunteers and families. This is because the nature and culture of the Esther Foundation created an environment where these types of unacceptable behaviours and practices could occur and go undetected.

Governance of the Esther Foundation was insular and nepotistic, which meant that people were reluctant to raise their concerns and lacked confidence that their concerns would be adequately and objectively addressed. There was difficulty attracting independent and appropriately skilled board members, and the board was unable to exercise effective leadership or manage risks. Many of the staff were former residents and unqualified interns who had no work experience outside the Esther Foundation; they had no context for expectations and standards in the broader health and community services sector. From its beginnings as a group of volunteers, the organisation struggled to evolve and professionalise its operations until late in its lifespan. Faith-based practice was a substitute for evidence-based treatment. The founder and former managing director of the Esther Foundation,

Patricia Lavater, was a singular and dominant influence and people were reluctant to speak out against her or make a complaint for fear of being penalised. There were limited independent complaints mechanisms within the organisation and no external body was clearly empowered to handle complaints.

Adequacy of actions taken by the organisation in response to complaints and allegations

The Esther Foundation board became aware of complaints in 2019. It conducted an internal investigation in relation to complaints from staff against Patricia and Rodney Lavater, and the newly appointed Chief Executive Officer later received complaints from former residents and reported on these to the board.

Following the complaints, the board made the decision to terminate Ms Lavater's employment although it did not censure Ms Lavater publicly. The board was aware that at least one former resident who had made a complaint was dissatisfied with this. The organisation did not publicly acknowledge the complaints and allegations, or offer an apology, until more emerged in the media in early 2022. This reflected that the board did not view itself as accountable for the organisation's culture or the behavior that was the subject of the complaints.

The Esther Foundation board was renewed from late 2019. It adopted a more professional and strategic approach, and focused on improving the organisational culture. However, the failure of the board Chairperson to resign reduced the credibility of the organisation's response to the complaints and allegations.

From 2020 onwards, the Esther Foundation devoted significant efforts and resources to improving its governance, professionalism and quality. This was both in response to the complaints, and in recognition that changes needed to occur in order for the organisation to be sustainable. The organisation restructured its staff and program, improved its policies and operational processes, embedded internal and external feedback channels, and began to pursue quality accreditation. However, reputational damage from the media reporting on the complaints and allegations was a key factor which led to funding withdrawal and the organisation entered voluntary administration in April 2022.

Gaps in existing legislative and regulatory frameworks

Existing legislative and regulatory frameworks for private healthcare facilities and mental health services did not capture the Esther Foundation to allow for oversight of its operations. The *Private Hospitals and Health Services Act 1927* (PHHS Act) is limited in its ability to regulate private accommodation-based mental health services because:

- some of the definitions are outdated and unclear
- there are no powers to inspect of audit unlicensed facilities to check if they meet the statutory definition and require a licence (which promotes an unsatisfactory self-regulatory model)

- key content is contained within the PHHS Act rather than the associated regulations, which limits the ability to respond to emerging issues.

The Department of Health's Licensing and Regulatory Unit (LARU) received information that led it to suspect that the Esther Foundation may have been operating as an unlicensed facility. However, the Esther Foundation did not identify itself as falling within the remit of the PHSS Act and LARU did not have the requisite powers to investigate the matter further or make a determination.

Aside from licensing, funding arrangements are the main mechanism by which government imposes quality and accountability requirements on mental health services. As an unlicensed and unfunded service, none of these requirements were enforceable in relation to the Esther Foundation.

Similarly, non-government AOD treatment services are only regulated through funding arrangements. A mandatory regulatory framework for AOD treatment services has emerged in the National Quality Framework for Drug and Alcohol Treatment Services. Western Australia is required to develop a regulatory process for enforcing this against services that do not receive government funding; however, this has not been progressed.

Why and how to regulate private mental health and AOD treatment services

Vulnerable consumers of private mental health and AOD treatment services are not adequately protected by the existing self-regulatory model. Private service providers fill a gap created by unmet need and can enhance diversity in these sectors, but there must still be a way to ensure the quality of these services. Unmet demand and lack of regulation may encourage growth of 'for profit' service providers in Western Australia, which may pose a greater risk to consumers. Regulation will support transparency, which enables consumers to make informed decisions about their treatment.

The Committee's three recommendations regarding regulation of private mental health and AOD treatment services are interrelated and contingent on each other:

1. There should be a statutory review of the PHHS Act to address its limitations as listed above, and consider whether accommodation-based mental health services should be put into a separate regulatory scheme.

2. A regulatory process must be developed to fully implement the National Quality Framework for Drug and Alcohol Treatment Services in relation to AOD treatment services that do not receive government funding.

3. A licensing and regulatory scheme should be established for private mental health and AOD treatment services, using a risk-based approach to determine the level of regulatory input required for different services.

Health Complaints Entities

Health complaints mechanisms complement regulatory regimes which act as a barrier to entry. The Health and Disability Services Complaints Office (HaDSCO) currently provides an impartial resolution service for complaints relating to health, disability and mental health services in WA. However, it does not have determinative powers and cannot undertake own motion investigations. Further, private unregulated health facilities may not fall under HaDSCO's remit if they do not meet the statutory definition of a 'health service'.

The recent passage of the *Health and Disability Services (Complaints) Amendment Act 2022* will expand HaDSCO's jurisdiction and powers in relation to unregistered health care workers, in accordance with the National Code of Conduct for health care workers. If this had been in place while the Esther Foundation was operating, HaDSCO would have been empowered to handle complaints about individual health care workers at the facility, but not the organisation itself. Western Australia should expand HaDSCO's jurisdiction and powers further to rectify the gap in relation to organisations that provide health services.

Even with the expansion of HaDSCO's remit, there are limitations in relying on health complaints entities to prevent LGBTQA+ conversion practices occurring, as evidence shows that these practices do not only occur within health care settings. Specific legislation has been introduced in other Australian jurisdictions to prohibit LGBTQA+ conversion practices, in recognition of the limitations of existing regulatory approaches and the significant harm caused by these practices. Western Australia should introduce legislation to prohibit conversion practices and establish a civil response scheme and supports for survivors of these practices.

Ministerial Response

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Education and Health Standing Committee directs that the Minister for Health and Mental Health and the Attorney General report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

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Over the duration of its operations, the Esther Foundation promoted itself as providing mental health, health and AOD treatment services, as well as a range of general support services.

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The Esther Foundation was insular and nepotistic, which meant that people were reluctant to raise their concerns and lacked confidence that their concerns would be adequately and objectively addressed.

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Governance of the Esther Foundation was weak. The board had difficulty exercising leadership and independence.

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The majority of staff had only trained within the Esther Foundation and had no experience in other organisations. This meant they had little to compare against and no context for expectations and standards in the broader health and community services sector.

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As the founder and managing director of the Esther Foundation, Patricia Lavater was a singular and dominant influence in the organisation and people were reluctant to speak out against her or make a complaint for fear of being penalised.

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There were limited formal mechanisms within the Esther Foundation that allowed for independent investigation and resolution of complaints, and no external body was clearly empowered to deal with complaints regarding the Esther Foundation.

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The National Quality Framework for Drug and Alcohol Treatment Services requires all alcohol and other drug treatment providers, irrespective of funding source, to be accredited against a recognised standard from 29 November 2022.

Finding 23 **Page 55**

Despite the requirement for Western Australia to develop a regulatory process to ensure that AOD treatment services that do not receive government funding comply with the National Quality Framework for Drug and Alcohol Treatment Services, this has not yet been progressed.

Finding 24 **Page 56**

Failing to regulate AOD providers who do not receive government funding exposes vulnerable consumers to potential harm, and undermines community confidence in the sector.

Chapter 6 – Why and how to regulate private mental health and AOD treatment services

Recommendation 1 **Page 66**

That the Minister for Health and Mental Health direct that a statutory review of the *Private Hospitals and Health Services Act 1927* be conducted, with particular consideration given to:

- updating and clarifying specific service definitions
- expanding the regulator's investigatory and enforcement powers
- allowing for services that require licensing to be prescribed within the regulations rather than the Act
- whether accommodation-based mental health services should be put into a separate legislative and regulatory regime
- whether AOD treatment services should be included as a prescribed service
- enabling transparency so that consumers can make informed choices when selecting a service.

Finding 34 **Page 67**

Full implementation of the National Quality Framework for Drug and Alcohol Treatment Services requires the establishment of a regulatory process for AOD treatment providers that do not receive government funding.

Recommendation 2 **Page 67**

That the Minister for Health and Mental Health ensures that a regulatory process for AOD treatment services is established, to give full effect to the National Quality Framework for Drug and Alcohol Treatment Services. This should involve consideration of a licensing scheme for AOD treatment providers.

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The National Quality Framework for Drug and Alcohol Treatment Services requires accreditation to demonstrate that minimum standards have been met. In developing a regulatory scheme for AOD treatment services, there is an opportunity to go beyond these minimum requirements.

Recommendation 3 **Page 72**

That the Minister for Health and Mental Health establish a licensing and regulatory scheme for private mental health and AOD treatment services, with particular consideration given to:

- developing sector-specific service definitions in consultation with the sector
- incorporating the requirements of the National Quality Framework for Drug and Alcohol Treatment Services
- incorporating sector-specific quality requirements
- using a risk-based approach to determine the level of regulatory input required for different services
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In instances where a facility does not meet the definition of a 'health service' under the *Health and Disability Services (Complaints) Act 1995*, the oversight role of the Health and Disability Services Complaints Office may extend to individual health practitioners, rather than the organisation as a whole.

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Finding 39 **Page 76**

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If the National Code had been in place while the Esther Foundation was operating, the Health and Disability Services Complaints Office would have had powers to handle complaints or concerns about individual unregistered healthcare workers.

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The implementation of the National Code addresses a number of existing regulatory gaps by providing the Health and Disability Services Complaints Office with greater powers and jurisdiction to handle complaints and concerns about individual unregistered health practitioners. This jurisdiction will not extend to the organisations where such health services may be provided.

Recommendation 4 **Page 85**

That the Minister for Health and Mental Health amends the *Health and Disability Services (Complaints) Act 1995* to provide HaDSCO with greater powers to handle complaints and concerns about organisations that provide health services. These powers should be comparable to the powers that HaDSCO will have in relation to individual healthcare workers through the implementation of the National Code of Conduct for Health Care Workers—including the ability to receive complaints, initiate own-motion investigations and issue prohibition orders.

In doing so, the Committee recommends consideration be given to:

- How HaDSCO's expanded jurisdiction in relation to organisations would complement the regulation of health services captured by the *Private Hospitals and Health Services Act 1927*.
- Whether a regulatory gap exists concerning complaints mechanisms for community services in WA, and whether it would be beneficial to broaden HaDSCO's jurisdiction to include community services.

Finding 42 **Page 87**

Expanding the jurisdiction and powers of the Health and Disability Services Complaints Office will not prevent LGBTQA+ conversion practices in Western Australia, as these practices occur both within and outside healthcare settings.

Recommendation 5 **Page 88**

That the Attorney General introduces legislation to prohibit conversion practices, and establish a civil response scheme and supports for survivors of conversion practices.

Chapter 1

The inquiry into the Esther Foundation and unregulated private health facilities

Referral to the Committee

1.1 The Legislative Assembly referred this inquiry to the Education and Health Standing Committee on 7 April 2022. In moving a motion to refer the inquiry, the Hon Simone McGurk MLA, Minister for Child Protection; Women's Interests; and Community Services, spoke about the reasons for establishing the inquiry. Minister McGurk said that at the beginning of 2022, 'allegations of abuse and inappropriate behaviours' at the Esther Foundation had been brought to her attention.[1] Subsequently, 'a large number of former residents' of the Esther Foundation approached the Minister's office 'outlining their experiences, including consistent allegations of abuse and inappropriate conduct.'[2] These complaints spanned over a significant timeframe, from 2004 to 2020.[3]

1.2 In establishing this inquiry, Minister McGurk sought to make it clear that the Committee was not being asked to investigate any criminal actions.[4] Rather, the role of the Committee would be to 'investigate how Esther Foundation and similar institutions could be properly regulated to prevent a recurrence of these sorts of events.'[5] The inquiry was established to hear from affected former residents and to examine regulatory improvements.[6] The Minister acknowledged the courage of the women who had come forward to share their stories to 'try to ensure that history does not repeat itself.'[7]

1.3 The Hon Amber-Jade Sanderson MLA, Minister for Health; and Mental Health, also spoke in support of the motion to refer the inquiry, firstly recognising the women who came forward to share their experiences at the Esther Foundation.[8] Minister Sanderson identified that in addition to hearing complaints, the role of the Committee would be to provide guidance on what regulatory gaps exist, and what policy levers might be available to address these. The Minister identified a particular focus that she hoped to see addressed by the Committee—namely, looking at opportunities to strengthen accountability measures, including legislative or regulatory reform.[9] The Minister identified that the Department of Health, Mental Health

1 Hon Simone McGurk MLA, Minister for Child Protection; Women's Interests; and Community Services, Legislative Assembly, *Hansard*, 7 April 2022, p. 1784.
2 *ibid.*
3 *ibid.*
4 *ibid.*
5 *ibid.*
6 *ibid.*
7 *ibid.*
8 *ibid.*
9 Hon Amber-Jade Sanderson MLA, Minister for Health; and Mental Health, Legislative Assembly, *Hansard*, 7 April 2022, p. 1785.

Commission, and Health and Disability Services Complaints Office would be well placed to contribute to the inquiry.[10]

Co-option of a Member to the Committee

1.4 On 16 June 2022, a motion was passed in the Legislative Assembly, co-opting Mr Stuart Aubrey MLA, Member for Scarborough, to participate in the Committee's inquiry. In speaking to the motion, the Hon David Templeman MLA, Leader of the House, expressed that 'the member for Scarborough has indicated a deep interest in the inquiry that is currently underway on the Esther Foundation, and his co-option is supported.'[11]

Scope of the inquiry

1.5 The Esther Foundation was a residential facility that promoted itself as providing a broad range of health and other services. Evidence to the inquiry noted that legislative and regulatory frameworks must have capacity to respond as facilities increasingly move towards holistic service provision to meet people's diverse needs. In particular, there is significant overlap across the health, AOD treatment, mental health, housing and community service sectors.

1.6 However, having regard to the terms of reference that directed the inquiry towards unregulated private health facilities, and the portfolio responsibilities of this Committee in health and mental health, we focussed our work primarily on legislative and regulatory frameworks for private health, alcohol and other drug (AOD) treatment, mental health services, and health complaints entities.

1.7 Some of the submissions to the inquiry addressed other cross-sector frameworks, such as Working with Children Checks. The Esther Foundation was also a service used periodically to provide placement for children in the care of the CEO of the Department of Communities, and it was historically registered as a housing provider. While we received some evidence about this, it was beyond our capacity to closely examine the limitations of the legislative and regulatory frameworks in these areas.

1.8 Some witnesses also raised concerns about the need to better regulate and support good governance in charities and community organisations. These issues are also outside the scope of this inquiry.

1.9 In relation to the complaints and allegations concerning the Foundation, we were cognisant of our limitations in investigating or determining individual complaints—and, in particular, those of a criminal nature. Our approach to this aspect of the inquiry is discussed further in Chapter 3.

1.10 It is somewhat unusual, although not completely unprecedented, that parliamentary committees are required to inquire into complaints about a private organisation. Through

10 Hon Amber-Jade Sanderson MLA, Minister for Health; and Mental Health, Legislative Assembly, *Hansard*, 7 April 2022, p. 1785.

11 Hon David Templeman MLA, Leader of the House, Legislative Assembly, *Hansard*, 16 June 2022, p. 2951.

the inquiry process, we observed that the absence of an external complaints mechanism with the ability to resolve complaints about the Esther Foundation is what ultimately led to these complaints being directed to the Committee. This speaks volumes about the need for regulatory reform to ensure that in the future, affected people can have their complaints dealt with by a dedicated body that is positioned to deliver better outcomes for individual complainants.

Conduct of the inquiry

1.11 A notice was placed in the West Australian on 16 April 2022, outlining the terms of reference for the inquiry and providing information about how to make a written submission. We also wrote to a number of stakeholders inviting submissions. This is standard practice at the beginning of committee inquiries. However, we tried to offer other pathways to give evidence, in recognition of the various reasons that some people involved with the Esther Foundation may have found it difficult to make a written submission. This included an option to submit a video or audio recording. The Committee also resolved to accept submissions from former residents, staff, volunteers and families involved with the Esther Foundation beyond the originally published due date of 3 June 2022. Information about these pathways was published on the inquiry website. In particular, the extended timeframe had a significant impact on the number of individual submissions we received in total. We continued to receive individual submissions to the inquiry up until 11 November 2022.

1.12 Early in the inquiry, we also liaised with Minister McGurk's office to establish a process to receive complaints directly from them, where those individuals gave consent for their complaint to be shared to the Committee as part of the inquiry. This avoided some people having to repeat their complaints.

1.13 From the outset, we made it clear that any evidence provided to the inquiry by individuals would not be published without consent. This information was published on the inquiry webpage, communicated directly to individuals who contacted us, and provided to individuals whose complaints were forwarded to us from Minister McGurk.

1.14 The Committee held a briefing early in the inquiry with a registered psychologist who advised the Committee on using a trauma-informed approach. Where individuals attended hearings, professional counselling services were available to witnesses on the day of the hearing. Witnesses were also invited to bring a support person with them to the hearing.

1.15 Minister McGurk's office provided us with a list of support services that women impacted by the Esther Foundation were able to access on a priority basis. This information was published on the inquiry website and is contained in this report at Appendix 2. Also contained at Appendix 2 are contact details for the Office of the Commissioner for Victims of Crime. These resources are available to all individuals impacted by the Esther Foundation, not just those who made a submission to the inquiry.

Evidence from individuals

1.16 The Committee received evidence from 76 individuals who were involved with the Esther Foundation as former residents, their family members or supporters, staff, contractors and service providers, and volunteers.

1.17 We recognise that many of these people had to overcome significant barriers to participate in the inquiry. This included fear of speaking out, unfamiliarity with inquiry processes, and the negative effects of reliving traumatic experiences. We thank them for taking the time to contribute to the inquiry by sharing their experiences, and we commend their strength and resilience.

1.18 In addition to complaints, we also received a number of submissions in support of the Esther Foundation—former residents who credit it as a major part of their rehabilitation, and people who had positive things to say about the assistance it provided to vulnerable women over many years.

1.19 Individuals who made submissions to the inquiry expressed different preferences for identifying themselves and publishing their evidence. This was also reflected in the media reporting on the complaints and allegations against the Esther Foundation, with some former residents choosing to identify themselves publicly, and some preferring to remain anonymous. We recognise some people may find that speaking publicly is empowering, and some have felt able to speak more freely in private.

1.20 Parliamentary committees perform a different function to the media. Privacy has allowed witnesses to give information to the inquiry freely without the complication of media or other factors weighing in on their evidence, or exposing them to the risk of further victimisation. This was of paramount importance to the Committee.

1.21 After careful consideration, the Committee chose to keep individual submissions private, to conduct hearings with individuals in closed session and to anonymise personal evidence in the report. In doing so, the Committee does not intend to silence or disempower people. Rather, in considering the complaints as a collective body of evidence, we have been able to identify consistent themes and practices that are unacceptable in a residential health facility and use this information to identify areas for reform. Many witnesses recognised this as the most desirable outcome of this inquiry and expressed a hope that by sharing their experiences, they could help prevent unacceptable practices occurring in the future.

1.22 Submissions and transcripts of closed evidence from individuals will not be disclosed, although throughout the report we have quoted from or referred to them with permission from the witness.

1.23 The Committee also received submissions with complaints and allegations against other unregulated private health facilities that continue to operate in Western Australia. Some of these revealed similar themes to the complaints and allegations against the Esther Foundation, as well as other issues which are beyond the scope of this inquiry. To the extent that they are relevant to the scope of this inquiry, we have used these submissions to inform our identification of the systemic gaps and options for addressing these.

Evidence from the Esther Foundation

1.24 Shortly after the commencement of this inquiry, the Esther Foundation entered voluntary administration. The predicted outcome of the administration process was the closure and winding up of the Esther Foundation. Given these circumstances, the Committee requested that the Clerk of the Legislative Assembly issue a summons to the administrator to produce documents to the Committee to assist the inquiry. The Committee received a large volume of operational and governance documents from the Esther Foundation from 1 January 2005 onwards, including board meeting minutes, annual reports, and policy and procedure documents.

1.25 The Committee also received written submissions from and held closed hearings with key personnel from the Esther Foundation:

- Patricia Lavater, who was the founder and Managing Director from inception to 2020
- former board representatives, Annette Latto (board member and Chairperson from 2015 to 2022) and Jeroen Bruins (board member from December 2019 to 2022, and Deputy Chairperson from May 2020, and former interim CEO, Philip Sparrow (from April 2022)
- former Chief Executive Officer, Anina Findling (board member and Treasurer from May 2019; Executive Officer from September 2019; CEO from November 2019 to June 2021).

1.26 This was also received as closed evidence and won't be published in full, although throughout the report we have quoted from or attributed certain information to this evidence.

1.27 The former Esther Foundation administrator, Mr Rodney Lavater, wrote to the Committee on 25 August 2022 advising that he would not be participating in the inquiry—Mr Lavater did not make a submission or attend a hearing.

1.28 In accordance with the Speaker's Procedural Rules, the Committee notified Ms Lavater, the former board representatives and Mr Lavater of significantly adverse references made against them in this report, and gave them an opportunity to respond.

1.29 Ms Lavater and the former board representatives were also given an opportunity to respond to significant adverse findings prior to publication of this report. Their responses are included at Appendices 3 & 4.

Evidence from government agencies

1.30 In addition to public hearings with the Department of Health and the Mental Health Commission, the Committee also held a briefing with representatives of these agencies early in the inquiry to gain an understanding of the relevant existing legislative and regulatory frameworks.

1.31 Submissions received from government agencies have been published. We did not publish all supporting documentation associated with these submissions, where they contained commercial agreements with third parties that contained confidentiality clauses.

Evidence from sector stakeholders, advocacy groups and subject matter experts

1.32 We have published the submissions received from a range of sector stakeholders, advocacy groups and subject matter experts. Where these submissions included personal accounts of individuals' experiences at the Esther Foundation that were identifying, we retained those portions of the submissions as closed evidence.

Chapter 2

What was the Esther Foundation?

2.1 In undertaking this inquiry, it was necessary to consider what sort of organisation the Esther Foundation was. This was essential to contextualising complaints concerning the Foundation, and the organisation's response. It was also necessary in considering what relevant legislation and regulations already exist for similar types of organisations, why the Foundation was not captured by existing frameworks, and options for regulating like facilities.

2.2 During our inquiry it became evident that, among the wide range of stakeholders we heard from, there was no consensus about what sort of facility the Esther Foundation was. The Esther Foundation promoted itself as providing a diverse range of support services for individuals with very different needs—among these there was consistent mention of AOD treatment, mental health, and health services.

Stakeholders in the mental health and AOD treatment sectors identified a lack of clarity about the services provided by the Esther Foundation

2.3 We received evidence that the definition and nature of services provided by the Foundation was unclear and blurred,[12] and there was 'such a broad range of things' that the Esther Foundation claimed to be responding to.[13] The Western Australian Network of Alcohol and other Drug Agencies (WANADA) understood the Esther Foundation as being an AOD treatment provider which addressed a range of complexities associated with intersecting issues.[14] However, unlike the majority of AOD treatment services that are visible to the peak body, the Esther Foundation existed on the fringe of the sector for many years. The CEO of WANADA told us that:

> I have been aware of Esther Foundation for 20-plus years, but it is like: "Who are they? Where are they?" We do not even know. They do not reach out. We do not have any communication. They do not attend any networks. So they do fly under the radar.[15]

2.4 Not everybody who went to the Esther Foundation needed support for AOD issues. The Western Australian Association for Mental Health (WAAMH) was aware of people seeking mental health support from the Foundation, unrelated to an AOD issue.[16]

12 Mr Lindsay Hale, Deputy Commissioner, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 6; Mr Alex Arpino, Development Coordinator, AODCCC, *Transcript of Evidence*, 3 August 2022, p. 2.
13 Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Transcript of Evidence*, 17 August 2022, p. 13.
14 Ms Jill Rundle, Chief Executive Officer, WANADA, *Transcript of Evidence*, 17 August 2022, p. 13.
15 *ibid.*, p. 8.
16 Ms Taryn Harvey, WAAMH, *Transcript of Evidence*, 17 August 2022, p. 13.

2.5 The Alcohol and Other Drug Consumer and Community Coalition (AODCCC) identified that religious engagement was a central element of the services provided by the Foundation:

> The perspective generally was that they [the Esther Foundation] were certainly engaging individuals that had alcohol and other drug issues, some mental health issues, but it was very much framed in [terms] of religious engagement, so they had a very firm belief system that was put onto the participants... [17]

2.6 The AODCCC also observed that once individuals accessed services at the Foundation, they would disengage from other service providers.[18]

What did the Esther Foundation see itself as?

2.7 The operations of the Esther Foundation spanned over a number of years and the organisation existed in various iterations—transitioning from its establishment as 'Esther House', to the 'Esther-Elizabeth House', and finally to the 'Esther Foundation'. An organisation profile published by the Esther Foundation describes a history of its operations.

Box 1: History of the Esther Foundation

- The residential program of the Esther Foundation has been operating since 1994, after being originally set-up by New Day Ministries charity arm, Living Hope. Living Hope operated a program for young women within an accommodation/care house that was called 'Esther House'.
- New Day Ministries disbanded its operations in May 2003 and ceased the operation of its charity arm, Living Hope. Patricia Lavater, who had coordinated and developed the program, sought to continue the work of the residential program.
- An individual offered the support of his organisation as an interim parent body for the residential program to continue until an independently incorporated foundation could be established.
- With this organisational and administrative support, a house was sought to accommodate the transition of young women from one organisation to another. The organisation was named 'Esther-Elizabeth House' in June 2003.
- Esther-Elizabeth House was soon operating seven houses in South Perth, with thirty young women and their children in residence.
- In December 2005 the organisation was incorporated and named the 'Esther Foundation'. In 2006 the organisation received a charitable collections licence, became registered as a public benevolent institution and was approved for deductible gift recipient allowances.
- Patricia Lavater was the founder and Director of the Esther Foundation, which officially became operational on 30 June 2006 as an independent incorporated body.

Source: Submission 50, Department of Communities, 'Organisation Profile – The Esther Foundation' p. 55.

17 Mr Alex Arpino, AODCCC, *Transcript of Evidence*, 3 August 2022, p. 2.
18 *ibid.*

2.8 The former Chairperson of the Esther Foundation, Mrs Annette Latto, described how the facility's inception stemmed from the actions of a group of friends in 2005:

> The original setup was run through a church that folded and then no-one picked it up, so they approached George O'Neil and said, "Would you auspice us?", which they did until they could sort out and get their ducks lined up and get their own incorporation happening, which was December 2005.[19]

2.9 Mrs Latto also shared an overview of how the Foundation had taken shape over the duration of its operations:

> When I came on board [in 2015], it [the Esther Foundation] was around—I am going to say residential rehabilitation, but it was more around providing residential support for ladies, some of which had come out of drug and alcohol. We did not take them using, so they came and either had to go cold turkey or they would come from being referred from another place. It was about trying to look at the whole person and give them the skills to then become functioning members back in society.
>
> …It grew out of its very early heydays. My understanding was that it was for heroin. So, back when it first started, heroin was very big in Perth. The foundation was primarily set up to try and help those women, and then it kind of organically grew. Right now, probably the biggest scourge is meth. We saw a transition. Like in my time, it had already moved onto a range of different scenarios, but when we ended, it was probably more young women with children that had either come out of domestic violence or, because of their bad marriage or relationships, they had ended up in trouble, so it changed a little bit. It morphed from very much what was originally probably more around heroin addiction to just life issues.[20]

2.10 The former interim CEO and former Chairperson advised at the time of the allegations arising, the Esther Foundation was providing support for AOD issues, and co-presenting issues including domestic violence, homelessness and mental health issues.[21]

2.11 According to the Esther Foundation's constitution, the objectives and purpose of the Foundation remained consistent from its establishment as an incorporated association in 2006. The constitution identifies that the organisation aimed:

> To render spiritual oversight, care and assistance whether material or otherwise and such other help as may be deemed appropriate to meet the needs of people including without limitation either itself or in co-operation with other like foundations:
>
> (i) by establishing, developing and maintaining, within the framework of a structured Christian based program:

19 Mrs Annette Latto, Former Chairperson, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 4.
20 *ibid.*, pp. 2-3.
21 Mrs Annette Latto and Mr Philip Sparrow, Interim Chief Executive Officer, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, pp. 2-3.

(a) residential rehabilitation centres;

(b) counselling and support services;

(c) community outreach and awareness;

(d) life skill and recreational training, and vocational education;

(e) creative arts programs; and

(ii) by engaging in any activity which is deemed by the Board to be advantageous in helping the community at large[22]

2.12 The Esther Foundation was registered as a charity with the Australian Charities and Not-for-profits Commission (ACNC) in 2012 when the charity regulator was established.[23] Upon ceasing to operate in 2022 its charity program was listed under the classification of 'Mental healthcare'.[24] The Foundation's listing on ACNC's register of charities summarises its activities:

> The Charity's program advances health and social or public welfare by providing extensive support for young women to overcome life controlling struggles such as substance abuse, sexual and emotional abuse, domestic abuse, domestic violence, mental health, pregnancy and self-harm in a safe, structured and supportive environment.[25]

2.13 Prior to ceasing operations in 2022, the Esther Foundation's website listed the most recent information about its facility and program:

> The Esther Foundation facilitates an extensive and award winning young woman's residential recovery and empowerment program which is now based in Kalamunda. The program provides intensive support for young women to be able to overcome life controlling struggles and issues in a safe, structured and supportive environment.
>
> The holistic recovery program aims to educate, empower and enrich young women with self-worth, employment skills and confidence to lead successful lives within the community. The Foundation is currently providing residential accommodation for approximately 30 young women, mothers and their children.
>
> …The broadly structured program facilitates specific group and individual counselling to help manage socially prevalent issues and concerns faced by young women including substance abuse, sexual and emotional abuse, domestic violence,

22 Esther Foundation, *Constitution: The Esther Foundation*, 2020, pp. 8-9. The objectives and purpose of the organisation are described in nearly identical terms in earlier iterations of the Constitution from 2006, 2014, 2017, and 2018.

23 Australian Charities and Not-for-profits Commission, *The Esther Foundation Incorporated: Registration status history*, accessed 25 August 2022, <https://www.acnc.gov.au/>.

24 Australian Charities and Not-for-profits Commission, *The Esther Foundation Incorporated*, accessed 25 August 2022, <https://www.acnc.gov.au/>.

25 *ibid.*

> mental health, pregnancy and self-harm, family breakdown, depression and eating disorders…[26]

2.14 Program application forms asked applicants to detail their criminal record and court proceedings, children, medical history, education and work history. Applicants were also required to consider a lengthy checklist of current or previous issues that they may have 'struggled with'. The contents of the list varied slightly over several versions of the form we have seen, although categories included emotional and behavioural issues, self-punishment, abuse to others, activity addiction, substance addiction, sexual addiction and experience of trauma. This reflects the broad range of issues that the Esther Foundation offered support for. However, some particular aspects of the application form checklists are, in our view, concerning and reflect the program's particular ideology in relation to homosexuality and religious beliefs. Our concerns in relation to these are discussed in Chapter 3.

Finding 1

Over the duration of its operations, the Esther Foundation promoted itself as providing mental health, health and AOD treatment services, as well as a range of general support services.

2.15 Although the purpose and activities of the Esther Foundation are described in different terms over the duration of its operations, the Foundation consistently promoted that it offered mental health, health and AOD treatment services.[27] The complaints and allegations concerning the Esther Foundation that we received describe practices that are incompatible with established safety and quality standards for the mental health, health and AOD treatment sectors—these complaints are discussed in Chapter 3. The sorts of complaints mechanisms that would be expected to be in place at a residential facility like the Esther Foundation were largely absent—as discussed in Chapter 4.

2.16 Despite promoting itself as providing AOD treatment, health, and mental health services, existing safety and quality mechanisms for these services did not capture the Esther Foundation. Emerging regulatory mechanisms for AOD treatment services that would apply to the Foundation were not yet enforceable. As a Committee, we considered these regulatory gaps and options for implementing regulations that would capture a facility like the Esther Foundation—these issues are discussed in Chapters 5, 6 and 7.

26 Esther Foundation, *About Us*, accessed 25 May 2022, <website no longer active>.

27 Australian Charities and Not-for-profits Commission, *The Esther Foundation Incorporated*, accessed 25 August 2022, <https://www.acnc.gov.au/>. See current listing and Annual Information Statements from 2013-2021.

Chapter 3

Complaints and allegations against the Esther Foundation

The Committee's approach to the complaints and allegations

3.1 Submissions received by the Committee contained a broad range of complaints and allegations regarding the Esther Foundation spanning a period from 2004 to 2020, although a small number did not specify a timeframe. The complaints were harrowing to read and we acknowledge the difficulty that people may have experienced in revisiting these experiences and the bravery they have shown in sharing their experiences with us.

3.2 In this chapter, we have reported on the prevalent and consistent themes that emerged in the evidence to the inquiry. The Committee is not in a position to report on every complaint and allegation we were told about, nor to investigate individual incidents. However, we have later made findings about the culture and nature of the Esther Foundation that created an environment where we believe these types of unacceptable behaviours and practices could occur.

3.3 The themes are an example of the types of unsafe practices that can occur in unregulated facilities that provide support to vulnerable people, such as the Esther Foundation. In the later parts of this report, we look at the systemic gaps that could allow for these types of behaviours and practices to go unchecked, and options for addressing these.

3.4 Many of the complaints and allegations related specifically to the Esther Foundation's founder and former managing director, Patricia Lavater. Other complaints related to various staff members or the organisation more broadly. Both Ms Lavater and former board representatives responded to the complaints and allegations in written submissions and in closed hearings. Their responses are included at Appendices 3 & 4.

Overview of complaints

The program did not always meet residents' needs and expectations

3.5 The Committee heard from a diverse range of people who had sought support from the Esther Foundation. Their ages varied greatly, from children and adolescents to mature adults. Many residents had experienced previous trauma. People described needing help for mental health issues, including depression, anxiety and self-harm, AOD issues, or multiple issues. Of these, some were also simultaneously experiencing other challenges including homelessness and domestic violence.

3.6 Residents who needed a higher level of support included those experiencing major depressive episodes, psychiatric disorders and individuals who had attempted suicide. A

number of individuals who were seeking help for AOD addiction needed to undertake detoxification at the facility.

3.7 Former residents and their families commonly described how they were told the program could meet their specific needs, yet the services delivered did not align with what they understood would be provided.

3.8 One former resident told the Committee:

> Mum and a few other people told me [about the Esther Foundation], and I obviously had Google, so I did a bit of looking around. From what I could see, it looked like it was more for adults than it was for me. That was my first instinct, because a lot of the wording on the website was about domestic abuse and addiction, and I was a child… who had some anger issues… but then when we saw the youth coordinator, it was apparently all marketed for children. She said that she could help us and that it would be easy and that I would be safe and cared for, and I absolutely was not.[28]

3.9 A number of former residents and their family members described seeking professional help for mental health issues. Some people told the Committee that they saw the Esther Foundation as an alternative to other health facilities in WA:

> What I was told at that time was that it was this place that was a good alternative to, say, Hollywood clinic or some of the more really intense medical institutionalised places…[29]

> …I did not really want [my daughter] to go to Perth Clinic or somewhere like that, and looking back I probably should have. This looked good. It looked like the alternative.[30]

3.10 One former resident was discharged from a mental health ward to the Esther Foundation:

> They were going to help me heal with my trauma. They were going to help me with my mental health. There were lots of things that I was promised. They were going to help me with my education. I also had an eating disorder; they were going to help me with that. There were lots of areas in my life—anything that I needed help with, apparently they were the miracle workers. That was what we thought.[31]

3.11 However, once she started the program:

> From the day I walked in there—obviously coming from a mental health ward, I was on medication, and I also had an outreach mental health nurse that worked with you; I saw her as well—they cut all of it. So, they took me off my medication. I

28 Closed evidence.
29 Closed evidence.
30 Closed evidence.
31 Closed evidence.

was no longer allowed to see my mental health nurse. Not once did I see a psychiatrist or a doctor or anyone for my mental health.[32]

Emotional and psychological abuse

When I came into the program, I often used to cry. This was a natural emotional response to what I was experiencing… I was repeatedly told that I was self pitying, and shamed for crying.

- A former resident

3.12 Emotional and psychological abuse by Esther Foundation staff was the most prevalent theme amongst the complaints and allegations we received. There was no single type of experience but witnesses commonly described feeling fearful, ashamed and controlled. Examples of the experiences reported to us include:

- residents being told they were attention seeking when disclosing past trauma or self-harming[33]
- residents being told their trauma or mental health issues were made up or that they brought it on themselves[34]
- residents being told their trauma was not severe enough to justify a mental health diagnosis or professional treatment[35]
- residents being made to participate in group sessions where people would take turns to shame or denounce others.[36]

3.13 Many witnesses reported that they wanted to leave the Esther Foundation at various stages but found it very difficult to do so because they were afraid of what would happen to them if they did or they felt manipulated into staying. Some residents reported being told they would go to hell, die or be raped if they left the program.[37] Another feared being spoken down upon or humiliated by staff and remaining residents if they left because they had witnessed this happen to others.[38]

We quickly learnt that we weren't allowed to express our emotions or talk about our feelings, because that was seen as us playing the victim.

- A former resident

32 Closed evidence.
33 Closed evidence.
34 Closed evidence.
35 Closed evidence.
36 Closed evidence.
37 Closed evidence.
38 Closed evidence.

I wasn't Christian nor was I opposed to becoming Christian however religion should have been something I came to on my terms, I should not have been forced to do it, pressured into it, told I was going to hell if I didn't and coerced into becoming a Christian.

- A former resident

Religious practices

3.14 Christian belief was not a condition for acceptance into the Esther Foundation program, although attendance at Sunday church services and youth groups was compulsory for residents. Completion of a series of religious reading and writing assignments was also a requirement for graduation from the program. The organisation claimed that other religious aspects of the program, such as prayer meetings and Bible study, were optional. However, former residents allege they were forced or coerced to attend these and to participate.

3.15 Witnesses told us that certain Christian practices at the Esther Foundation were often traumatic, including prayer meetings late into the night, being held down forcibly for exorcism or 'deliverance' of demons, and faith healing. Although many people involved with the Esther Foundation identified as Christian, some of them described Ms Lavater's religious practices as 'more extreme than I would like',[39] 'controversial' and 'cultish'.[40]

3.16 Witnesses told us there was no tolerance of divergent beliefs, even where people agreed to respect the Christian context of the program.[41] The program guidelines from 2019 reflect that media and items viewed as contradictory to Christian beliefs were forbidden. Music, television and movies were to be preapproved by staff, with a specific ban on media containing 'occult references' and 'witchcraft', as well as swearing and violence. Christian radio was approved. 'Occult practices' such as witchcraft, tarot cards, dream catchers and other related material were also forbidden. Witnesses told us that items deemed to be in contravention of these guidelines would be confiscated or destroyed, including metal band t-shirts and jewellery with crystals. Program application forms from 2019 and 2020 asked applicants to identify if they had 'struggled with' issues of 'self-punishment', including 'spiritual (participating in the occult)', which, in our view, indicates an overly restrictive view on acceptable spiritual beliefs.

If any girl tried to move during prayer, the people praying would say that the devil was coming out of her and they'd continue to hold her down forcibly. I was held down in prayer against my will, but I thought it was normal and let it happen to me.

- A former resident

39 Closed evidence.
40 Closed evidence.
41 Closed evidence.

LGBTQA+ suppression and conversion practices

> ***I would try to act and be 'straight', because I knew that I had to be accepted by them. I was at a point in my life where I needed love and acceptance and support, and I would only get that if I were 'straight'.***
>
> *- A former resident*

3.17 Several people reported being subjected to or witnessing LGBTQA+ suppression and conversion practices. Examples of the experiences reported to us include:

- residents being told their homosexuality was caused by demons that needed to be removed through prayer[42], or was responsible for their suicidal behaviours[43]
- a resident being made to confess any 'gay thoughts' to staff in meetings[44]
- a resident being told they could be cured from being gay, encouraged to dress more feminine and being given workbooks on how to be a 'godly wife'[45]
- a lesbian volunteer who was told she was no longer allowed to attend the Esther Foundation because she had been seen at The Court Hotel and was 'a source of corruption' to residents[46]
- residents who were attracted to each other being pitted against each other as either a 'predator' who would make the other resident fail in her recovery, or as a 'victim' who mistakenly thought they were gay simply because someone was trying to 'seduce' them[47], or a teenage resident being told she was a paedophile and a predator for being in a relationship with a resident who was 9 months younger.[48]

3.18 Esther Foundation application forms from 2019 and 2020 asked applicants to identify if they had 'struggled with' issues of 'sexual addiction', which was particularised as including pornography, masturbation, sexual fantasy and homosexuality. This suggests that within the program, homosexuality was considered to be disordered, which is a key assertion of conversion ideology.[49]

> ***During the times I realised the conversion tactics weren't working I would become suicidal as I believed I was a bad person and deserved to be in hell.***
>
> *- A former resident*

42 Closed evidence.
43 Closed evidence.
44 Closed evidence.
45 Closed evidence.
46 Closed evidence.
47 Closed evidence.
48 Closed evidence.
49 Sexual Orientation & Gender Identity Change Efforts Survivors, *SOGICE Survivor Statement*, July 2020, p. 2.

Culturally harmful practices

3.19 Several witnesses reported that the cultural identity of Aboriginal residents was suppressed and treated with contempt.

3.20 One Aboriginal resident reported that:

- she was told that speaking about Aboriginal issues or alleging discrimination was 'incoherent' and a paranoid symptom; she was later banned from speaking about Aboriginal rights and issues and threatened with ejection from the program if she continued[50]
- over time, she was separated from her family members who were also residents at the Esther Foundation; she was told that this was because they needed to break Aboriginal bonds that were evil[51]
- she was accused of witchcraft and 'pointing the bone'[52]
- she was asked to perform Aboriginal dances in church, to 'shake off ancestral spirits', which was 'humiliating' and 'making fun'.[53]

3.21 The witness reported that she was 'tormented' by these experiences and they have had a devastating impact on her cultural identity as an Aboriginal woman.[54]

Medical complaints

3.22 A number of former residents reported that:

- they were denied medication that had been prescribed to them prior to entering the Esther Foundation, often going 'cold turkey'[55]
- they were administered medication, sometimes forcibly, that had not been prescribed for them personally—including antipsychotics and diazepam[56]
- they were diagnosed with medical or mental health conditions by staff who were not qualified to do this, and these diagnoses were later confirmed to be incorrect[57]
- access to healthcare practitioners was limited in frequency and choice, and medical issues went unaddressed.[58]

Lack of structured program

3.23 We were told that many aspects of the program seemed to be decided on a 'make it up as you go along' basis.[59] There were some standard elements of the program, such as an initial 30-day period where incoming residents would have no contact with family or friends, and

50 Closed evidence.
51 Closed evidence.
52 Closed evidence.
53 Closed evidence.
54 Closed evidence.
55 Closed evidence.
56 Closed evidence.
57 Closed evidence.
58 Closed evidence.
59 Closed evidence.

no access to a mobile phone or their wallet. Several witnesses told us that even minor 'relapse' incidents could result in these restrictions being extended for up to several months.

3.24 Former residents told us that while there were some specific requirements for graduation, such as completion of various assignments and workbook tasks, graduation ultimately depended on Ms Lavater deciding that residents were 'ready'. This could also be delayed for reasons that were not always clear.

3.25 Some residents stayed in the program for many years and reported feeling institutionalised and struggling to adapt after leaving.

Inappropriate responsibility given to residents

3.26 The program included a system where established residents would be appointed as leaders to supervise others. In part, this was to give residents a form of work experience as interns. Former residents also frequently went on to become paid staff members. However, several witnesses reported being given an inappropriate level of responsibility in supervising or caring for other residents—for example:

- unqualified and underage residents being made to sleep in the same room and be responsible for newly arrived detoxing residents[60]
- an underage resident being left in charge as a house leader while staff went to search for a resident who had run away[61]
- a young adult looking after a young child for several days while the child's mother was away.[62]

Education

3.27 Several witnesses have reported that their education was neglected while they were residents at the Esther Foundation and that the compulsory education program for school-age residents was not delivered as promised.

3.28 At various stages, there appear to have been efforts to integrate some residents back into mainstream schooling.[63] However, for the most part, the education program consisted of two days of curriculum delivery from an external provider, Alta-1. This then shifted to online schooling. One witness told us:

> The girls would sit there in front of a computer screen with no help; there was no one there… They were so far behind. There were no tutors… It was the secretary who would come in and yell at them and say, "Be quiet." That was the tutor.[64]

60 Closed evidence.
61 Closed evidence.
62 Closed evidence.
63 Esther Foundation, Annual Report 2018.
64 Closed evidence.

3.29 Some people also reported being denied the opportunity to complete higher education, except for at bible college.[65]

Family alienation

3.30 Witnesses told us that Esther Foundation residents were alienated and isolated from their families, even beyond the initial 30-day period. Some residents reported having their phone calls and letters with family monitored, not being allowed to visit family members who were hospitalised or near death, and being punished or shamed for challenging this decision.[66]

3.31 A former resident's parent reported that 'they would try to keep you away from your children as much as possible', residents were 'misled to believe that their parents do not want them', and that families had their contact further restricted whenever they asked questions or challenged staff decisions.[67]

Physical restraints and assaults

3.32 Several witnesses reported being physically restrained by staff or other residents at the Esther Foundation. This included being tied to another person or to a bed, being held down or sat on, or being locked in rooms. Some reported being slapped or being encouraged to slap another person. The complaints related to various contexts—attempted escape, prayer or 'deliverance' or being forcibly medicated.[68] Many witnesses reported running away to try to escape from the program, being forced into vehicles to return, and then punished or 'shadowed' so they could not escape again.[69]

Sexual assault

3.33 The Committee received evidence from several witnesses that they were sexually assaulted by a staff member while they were residents at the Esther Foundation. Some witnesses said that Ms Lavater was made aware of these allegations while she was the Managing Director of the Esther Foundation but did not take appropriate action.[70]

Other complaints

3.34 Other complaints received by the Committee included financial irregularities, including the organisation requesting resident's online banking passwords; working for the organisation without being paid, or excessive work; being required to do hard physical labour and extreme exercise; fat shaming, and poor quality or insufficient food.

3.35 There was also inadequate separation between residents from different age groups in the program. Adolescents resided with adults who had vastly different treatment needs. At times, adolescents were exposed to confronting behaviours and issues of adult residents experiencing AOD or mental health challenges, which were not suitable for them to witness.

65 Closed evidence.
66 Closed evidence.
67 Closed evidence.
68 Closed evidence.
69 Closed evidence.
70 Closed evidence.

Impacts on residents

I walked out of Esther with more issues than I walked in there with, not to mention I never dealt with the issues I went there for.

- A former resident

3.36 Former residents reported that their experiences at the Esther Foundation have had ongoing negative impacts in their lives. These include:

- delaying seeking further help because they were convinced their trauma wasn't true and they didn't need help[71]
- anxiety about accessing other services[72]
- mistrust of women in authority—for example, employers or doctors[73]
- broken family relationships[74]
- unable to trust, and difficulty forming and maintaining relationships[75]
- financial impacts of lost educational and job opportunities[76]
- deep fear of religion, God and hell[77]
- pursuing more extreme types of LGBTQA+ conversion therapy.[78]

Evidence in support of the Esther Foundation

3.37 The inquiry also received a number of submissions from former residents, staff and volunteers in support of the Esther Foundation and Ms Lavater. Some of these sought to discredit the complaints, or reported that former residents who have tried to share their positive experiences have been bullied or 'trolled'. Some highlighted the Esther Foundation's successes while also acknowledging its flaws and that some of the complaints were legitimate. Others pointed out that positive stories of the Esther Foundation had been ignored by the media, which had a deleterious effect on some former residents and compromised the qualifications and careers of many former staff.

3.38 Several former residents reported that the Esther Foundation took them in when they were in dire circumstances—they were facing imprisonment, had nowhere else to go, or had been unsuccessful in other treatment facilities. Some reported that the Esther Foundation supported them through relapses and accepted them back into the program on more than one occasion.

Without the program I shudder to think of how my life might have turned out.

- A former resident

71 Closed evidence.
72 Closed evidence.
73 Closed evidence.
74 Closed evidence.
75 Closed evidence.
76 Closed evidence.
77 Closed evidence.
78 Closed evidence.

3.39 Witnesses reported that although their recovery was challenging, staff were supportive, compassionate and dedicated. They credited the Esther Foundation with playing a pivotal role in their recovery from long-standing and serious issues. In addition to helping them overcome addiction and regain good physical and mental health, former residents attributed many other positive results from their time at the Esther Foundation, including:

- ending their criminal offending
- gaining qualifications and employment
- going on to further study and travel
- forming strong friendships and relationships
- achieving reunification with their children.

> ***Esther House was about the twentieth residential or in-house treatment facility I'd been in. It is the only one that changed me.***
>
> *- A former resident*

3.40 Some external evaluation reports also confirmed the positive impacts of the Esther Foundation program on some participants. An October 2020 evaluation of the St Emilie's facility and Esther Foundation program by the Department of Communities surveyed and interviewed a small number of staff (9) and residents (26) selected by the Esther Foundation. The evaluation noted that it had used a 'lite touch' approach and was 'not able to rigorously comment on effectiveness drivers/program quality'. However, it found that most residents had experienced positive shifts in their wellbeing in most survey areas, including overall satisfaction with and achievement in life, health and safety, and feeling part of the local community. Various aspects of the program, such as peer mentoring, professional counselling, work and training opportunities and family support for mothers, had average satisfaction ratings above 70 per cent.[79]

3.41 The Esther Foundation also commissioned Huber Social from 2020 to 2022 to measure the effectiveness of the program by measuring the shift in participants' subjective wellbeing and the program outcomes. Key findings of the social impact performance report in April 2022 included:

- Graduates had a 49 per cent higher wellbeing score than those at the 'baseline' (in their first month of the program)
- The factors with the biggest difference between baseline and graduation were life skills, mental wellness, substance abuse, financial stability, parent relationships and stability
- These shifts were either maintained or improved in the first three years after graduation, and alumni had a more stable life than before completing the program.[80]

79 Department of Communities, *Evaluation of St Emilie's Facility and Esther Foundation Program*, 9 October 2020.

80 Huber Social, *Social Impact Performance Report: The Esther Foundation*, April 2022.

Nature and culture of the Esther Foundation

3.42 As mentioned at the beginning of this chapter, this Committee is not in a position to make factual determinations about individual complaints and allegations against the Esther Foundation. However, from the evidence to the inquiry, we have been able to draw conclusions about the culture and nature of the Esther Foundation that created an environment where we believe that unacceptable behaviours and practices could not only occur, but also go undetected for a significant period of time.

3.43 We gave the former board representatives and Ms Lavater an opportunity to respond to our draft adverse findings. To the extent that they responded to these, their responses are included at Appendices 3 & 4.

Nepotism compromised the organisation's governance

3.44 Former staff and board members agreed that, for most of the period that it operated (up until 2019), the Esther Foundation was insular and nepotistic.[81] At various times, key staff and members of the board were related or had close personal friendships. Operational managers and staff members also served on the board, so there was no separation of powers and little representation of the interests of other stakeholders.

3.45 These arrangements compromised the independence of the organisation's governance, made it difficult to effect change, and gave rise to conflicts of interest that were difficult to manage. In this environment, it is easy to see that people would have been reluctant to raise their concerns and may have lacked confidence that their concerns would be adequately and objectively addressed.

3.46 The difficulties with this aspect of the Esther Foundation had been identified for some time but the organisation found it difficult to transition. We heard that this is common in small not-for-profit organisations.[82]

> Of course, you lean on your friends and family when you are in the early stages; they are the ones who will back you. But if that is what your organisation looks like 15 years on, you have got problems… because they will not hold you to account in the way that you need to be.[83]

Finding 2

The Esther Foundation was insular and nepotistic, which meant that people were reluctant to raise their concerns and lacked confidence that their concerns would be adequately and objectively addressed.

81 Closed evidence; Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, pp. 8, 15.
82 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 8.
83 Mr Philip Sparrow, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 22.

Governance was weak and there was little accountability

3.47 The complexity of running a trauma recovery program should have demanded strong governance structures. However, the governance structures at the Esther Foundation were generally weak and lacked personnel with diverse and appropriate skills. One former staff member gave evidence that the organisation had been built so long on 'crooked foundations' that 'it seemed an impossible undertaking' to make those foundations straight.[84] We were also told that the board had difficulty exercising leadership and was effectively a 'support group' for the founders.[85] Witnesses told us that there was long-standing difficulty attracting new members to the board who would bring independence and appropriate skills.[86] One former staff member told us 'some board members were in denial of how bad it was', and there was a 'head-in-the-sand' mentality and a culture of 'brushing things under the carpet.'[87] This was also demonstrated to some extent in the organisation's response to the complaints, which is discussed in Chapter 4.

> ***There was a culture of continual avoidance of difficult conversations. There was a culture of a lack of accountability and those are key problems.***
>
> *- A former staff member*

3.48 In this environment, the board was not able to exercise appropriate stewardship of the Esther Foundation or manage risks to the organisation.

3.49 We were told that building strong governance is another common difficulty with small charity organisations and that 'people who start organisations often have incredible independence and drive, but they also resist accountability, and that is where you get problems.'[88]

> Where I have witnessed so many amazing missions and well-meaning purposes go wrong is that, in addition to the lack of leadership training, support and accountability, charity leaders either completely ignore the need or else wait too long before bringing in other organisational leaders with those opposite/complementary skill sets who can help provide the necessary structures of order, transparency, professionalism, safety and accountability.[89]

Finding 3

Governance of the Esther Foundation was weak. The board had difficulty exercising leadership and independence.

84 Closed evidence.
85 Closed evidence.
86 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 8; Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, p. 5.
87 Closed evidence.
88 Mr Philip Sparrow, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 22.
89 Closed Submission 60, Mrs Anina Findling, p. 3.

Staff were inadequately qualified and had no external experience

3.50 When the Esther Foundation program began, no internal staff had any relevant formal qualifications.[90] Later, staff achieved qualifications in community services or youth work up to diploma or advanced diploma level.[91] As noted above, a key aspect of the program was residents training as 'interns', although internal documents from 2010 revealed that the in-house training system had some deficiencies, namely:

- it was not well defined or structured, relying mostly on 'osmosis' or interns just 'picking it up'
- it did not use research evidence to advance practice and policy, and
- there was no clear avenue for suggesting and implementing program improvements.[92]

3.51 Another difficulty we identified with the organisation's heavy reliance on an intern system is that it resulted in the majority of staff having no external experience—the Esther Foundation was the only work environment they knew. This accords with the evidence of some witnesses, who recognised that it was problematic that interns were expected to learn by modelling from staff who did not necessarily have the requisite skills themselves.[93] One witness described the culture at the Esther Foundation as 'clannish', and that 'they thought they had no need to learn from anybody else.'[94] In this environment, it is easy to see how the organisation could lose touch with broader community expectations around appropriate service delivery.

> ***… services and their employees can have good intentions but without appropriate professional evidence-based training and expertise (including peers), they fail to meet the needs of the consumer and place individuals at significant risk.***
>
> *- Submission 37, AODCCC*

3.52 The inquiry has received significant evidence about the importance of using lived experience to inform service provision and the benefits of developing a lived experience workforce in the AOD, mental health and community services sector.[95] However, lived experience cannot replace evidence-based, quality service delivery by appropriately qualified professionals.

> … peer workers add great value to the treatment experience, provide hope and expertise from direct lived experience. The preference is that consumers are provided a balance between a learned and a lived experience in treatment services.[96]

90 Closed evidence.
91 Closed evidence.
92 Closed evidence.
93 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 9; Closed evidence.
94 Closed evidence.
95 Submission 37, AODCCC, p. 2; Submission 58, WANADA & WAAMH, p. 1.
96 Submission 37, AODCCC, p. 2.

Finding 4

The majority of staff had only trained within the Esther Foundation and had no experience in other organisations. This meant they had little to compare against and no context for expectations and standards in the broader health and community services sector.

Lack of professionalism

3.53 The Esther Foundation did not begin to professionalise its operations until much later in its lifespan. This reflected its origins as 'a group of volunteers who were trying to help a few women.' By Ms Lavater's own admission, they were very 'green' when the organisation initially started and 'we ended up taking on a lot more than we expected.'

> Back then we probably made mistakes, in the sense that we were learning how to deal with women in crisis, and we probably, at times, would have been maybe unprofessional in the way that we were dealing with these young women.[97]

3.54 Lack of professionalism was also reflected in poor recordkeeping, which was evidenced in the incomplete documentation that was able to be provided to the inquiry under summons. We were told that that the program was disorganised, without any clearly defined management structure and no formal documentation (including case files and written policies), workflow and position descriptions.[98] Written policies and staff training to implement them were *ad hoc*, and the program had few formal structures.

3.55 In a rapidly expanding organisation, it is easy to see how professionalising operations may have less priority than simply meeting demand. However, the complexity of offering trauma recovery in a residential setting demands a professional, evidence-based approach to ensure that trauma isn't further compounded. This is particularly so when, by the Esther Foundation's own admission, they accepted 'some of the worst cases in WA coming in and asking for help because no-one else would take them in.'[99] A former medical practitioner said that she was 'amazed at some of the cases they have taken on, which many other rehabilitative or residential services would not accept.' She said they did this 'out of a compassionate heart' for those who had 'burnt their bridges' and had nowhere else to go.[100] However, even with good intentions, staff and organisations must be able to recognise the limitations of their capabilities.[101]

Finding 5

The Esther Foundation struggled to evolve from a volunteer-run organisation to a professionally-run organisation.

97 Ms Patricia Lavater, Founder and former Managing Director, Esther Foundation, *Closed Transcript of Evidence*, 21 September 2022, p. 4.
98 Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, pp. 3, 12.
99 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 4.
100 Closed evidence.
101 Submission 26, Anglican Diocese of Perth, p. 1.

Faith-based practice was a substitute for evidence-based treatment

3.56 Faith-based services are not, of themselves, problematic. In fact, we heard significant evidence in support of diverse mental health and AOD treatment services that meet the different needs of individuals and communities, including services where faith and spirituality may form an important part of someone's recovery. However, the benefits of these services for certain individuals can only be realised if they are supported by 'a stronger organisational culture and commitment to quality evidence-based practice.'[102] Where this does not occur, serious harm can be caused.

3.57 These difficulties have been exemplified in other controversies surrounding faith-based organisations seeking to assist vulnerable people—for example, Mercy Ministries[103] and the Healing House.[104] Some of the complaints in these instances are similar to those raised regarding the Esther Foundation.

3.58 In the case of the Esther Foundation, faith-based practice was relied upon as a significant portion of the program, and was coercive. There was little evidence to inform many other aspects of the program. This caused harm to some residents.

Finding 6

Faith-based practice formed the majority of the Esther Foundation's program and was a substitute for evidence-based treatment.

Patricia Lavater was a singular, dominant influence

3.59 Several witnesses told us that, as the organisation's founder, Ms Lavater sought to maintain significant control over many aspects of the Esther Foundation even as it grew to a size where that became unmanageable.

3.60 Internal documents demonstrate that this was the case for some time. In 2008, it was identified that the program was already becoming too big and complex for Ms Lavater to continue to 'micromanage' cases and that staff needed to become less dependent on her. A 2012 review noted 'ethical issues of power and control' over residents and staff, including that the organisation sought to control what staff did outside their employment time. 'Leadership being excessively controlling' was proffered as a 'probable' reason why many graduates and former staff were 'bitter' about their experience. There was also an identified need to develop a transition strategy for succession from the founders.[105]

102 Mr Colin Penter, Policy and Projects Officer, WAAMH, *Transcript of Evidence*, 19 August 2022, p. 17.

103 Ruth Pollard, 'Mercy Ministries home to close', *Sydney Morning Herald* (web-based), 28 October 2009, accessed 11 October 2022, <https://www.smh.com.au>; 'Exorcisms, cruel techniques' part of Mercy Ministry treatment', *ABC News* (web-based), 17 March 2008, accessed 11 October 2022, <https://www.abc.net.au/news/>.

104 Hagar Cohen, Jeremy Story Carter and Alison McClymont, 'Women speak out against controversial religious Sydney drug and alcohol rehabilitation centre the Healing House', *ABC News* (web-based), 16 December 2020, accessed 11 October 2022, <https://www.abc.net.au/news/>.

105 Closed evidence.

3.61 Other witnesses told us that 'we were always expected to have the same beliefs and opinions as Patricia and everything else was wrong'[106] and that she was 'beyond change', particularly in understanding the need to develop better governance and operational structures within the organisation.[107] The board told us that in the process of handling complaints from staff, it became clear that 'there was a lot of fear of management that if I say something, I am going to be penalised.'[108]

Finding 7

As the founder and managing director of the Esther Foundation, Patricia Lavater was a singular and dominant influence in the organisation and people were reluctant to speak out against her or make a complaint for fear of being penalised.

Complaints mechanisms were limited

3.62 A lack of independent and formal complaints mechanisms ignored the vulnerability of residents and many staff. This possibly explains why it took so long for many of the complaints to be raised with the organisation and later in the media.

The really difficult thing is when people have been suppressed for so long and they have been told they do not have a voice—or when they did try to speak, they were publicly humiliated. When I got into the culture, that was one of the most devastating things.

- A former staff member

3.63 Both the board and Ms Lavater told us that the board did not receive any formal complaints prior to 2019.[109] However, a board representative told us that 'cracks in the previous management approach' began to appear in 2018 with the move to Kalamunda.[110] The board created a grievance sub-committee to deal with a significant body of staff complaints that had emerged and external complaints from former residents that were received later in 2019.

3.64 A former staff member told us that prior to the grievance committee being established, complaints were 'all filtered through Patricia' and 'what Patricia did not like was not heard and did not go any further.' Because so many staff had been previous program participants 'it took so long to get them feeling safe to speak, because they had been suppressed and unheard for so long.'[111] The former board Chairperson agreed that the 'floodgate' opened when the board began taking complaints and it became evident that there would be a leadership change within the organisation. At that point, people felt safe to come forward and reassured that they would get 'reception.'[112]

106 Closed evidence.
107 Closed evidence.
108 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 10.
109 Closed Submission 64A, Ms Patricia Lavater, p. 4; Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 8.
110 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 8.
111 Closed evidence.
112 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, pp. 8, 17.

3.65 This contrasts starkly with what Ms Lavater told us, namely that participants were not discouraged from speaking and could do so at any time, without any adverse consequences.[113] However, Ms Lavater did agree that

> …yes, definitely, you would be fearful to be spoken to by the CEO of the organisation, especially if you are a traumatised, troubled young woman. I mean, as much as I could, I made myself available, but they definitely felt fearful to come and see the CEO.[114]

3.66 Ms Lavater told us that avenues for residents to make complaints and give feedback included:

- Writing a letter to her and she would read these weekly
- Attend a group run by her so participants could speak to her directly about any issues or cause for concerns
- Complete available feedback forms which were redirected to the appropriate staff member to deal with
- In person meetings weekly or fortnightly with their case managers to discuss their recovery progress and case needs
- In person meetings weekly or fortnightly with their team leaders to discuss their residency or concerns
- Weekly calls to speak to family members regarding anything of concern or feedback.[115]

3.67 What is common to nearly all of these avenues is that residents were expected to complain to the person who was potentially the subject of their complaint. There were no independent mechanisms, or formal escalation procedure if complainants were unsatisfied with the outcomes of their initial complaints. This shows an alarming lack of insight, particularly given the vulnerabilities of the residents at the Esther Foundation.

3.68 The need for a robust internal complaints handling mechanism was even more vital given there was no obviously apparent external body which was responsible for investigating complaints against facilities such as the Esther Foundation. Evidence we received about complaints raised with external organisations is contained in Box 2. As a federal agency, the role and investigatory power of the Australian Charities and Not-for-profits Commission is out of scope for this inquiry. However, it is worth noting that the ACNC is not empowered to investigate concerns regarding the quality of services a charity provides.[116]

3.69 The role and limitations of health complaints entities are further discussed in Chapter 7.

113 Closed Submission 64A, Ms Patricia Lavater, p. 4.
114 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 14.
115 Closed Submission 64, Ms Patricia Lavater, p. 8.
116 Australian Charities and Not-for-Profits Commission, *What the ACNC can not investigate*, accessed 11 October 2022, <https://www.acnc.gov.au/>.

Box 2: Complaints made to external organisations

During this inquiry, we heard from individuals who had contacted various external bodies to make a complaint about the Foundation. One of these was a complaint to the Mental Health Commission in 2018, which is outlined in the case study in Chapter 5.

In 2018, the same former resident made a complaint to the Australian Charities and Not-for-profits Commission (ACNC), which detailed events they had experienced or witnessed at the Esther Foundation. The complaints raised were consistent with the themes of complaints identified in this chapter. The complainant did not receive a reply from the ACNC.

Another complaint was made to the ACNC by the parent of another former resident, in 2019. The ACNC did not respond to the complainant about their concerns and it's not clear what action—if any—the ACNC took in response to the complaint. We heard that shortly after the complaint was made with the ACNC, the complainant had noticed improvements at the Esther Foundation. Around the same time, the complainant also raised concerns directly with the Foundation.

In 2019, this complainant also raised concerns with Child Protection and Family Support, within the Department of Communities. The complaint primarily related to a misrepresentation by the Foundation about guardianship requirements for school enrolments. The complainant also said that 'I've heard the workers tell the girls Patricia (Director) is their Guardian now. Patricia also tells the girls she is their guardian. Girls are also misled to believe their parents do not want them. I have heard this while at the Foundation.' The response from Child Protection and Family Support said that the concerns raised were outside of their role and advised the complainant to contact the Department of Education.

The complainant raised concerns relating specifically to education with a Department of Education Regional Office. Although the Regional Office was responsive to the concerns raised, they were unable to take action and instead advised of other organisations that may be able to assist.

Source: Closed evidence.

Finding 8

There were limited formal mechanisms within the Esther Foundation that allowed for independent investigation and resolution of complaints, and no external body was clearly empowered to deal with complaints regarding the Esther Foundation.

Unacceptable practices occurred at the Esther Foundation

3.70 Despite what many witnesses have said were the altruistic intentions of the Esther Foundation, the factors listed above combined to erode accountability within the organisation. Unacceptable practices were able to take place and people felt unable to speak out against them or, where they did, their complaints were not heard. Particularly in light of the unique vulnerabilities of former residents and many staff, this created an unsafe environment.

Finding 9

Unacceptable practices occurred at the Esther Foundation which caused harm to residents, staff, volunteers and families.

Chapter 4

Adequacy of actions taken by the organisation in response to complaints and allegations

The Esther Foundation made significant efforts to improve

4.1 The board told us that changes made from 2020 onwards were

> in response to direct observations, several complaints, and a growing recognition of a need for a more professional and modernised approach. This culminated in Board-led decisions to comprehensively revise and improve structure, staff and process.[117]

4.2 This chapter outlines many of the organisational changes that the Esther Foundation undertook in response to the complaints and allegations it received. Ultimately, it is clear that significant effort and resources were devoted to improving governance, professionalism and quality standards, which was a substantial undertaking and an entirely appropriate response to the complaints. For the most part, it seems that the organisation executed these reforms well. There are some instances, outlined below, where the organisation's response compromised its accountability and credibility.

The board became aware of complaints in 2019

4.3 The board told us that one of its actions in response to the complaints was to conduct 'in-depth conversations and mediation with the residents who had initiated complaints, including receiving suggestions from them as to actions they would like to see taken.'[118]

4.4 Evidence from the Esther Foundation board indicated that it started dealing with complaints from early 2019. Initially, these were staff complaints which related primarily to both Rodney and Patricia Lavater, as 'moving to Kalamunda was when the cracks in the previous management approach really became evident.'[119] The board conducted an internal investigation:

> We gave each of the staff who had been involved in those complaints an opportunity to meet with us to just tell their side of the story, but also to be able to talk about both parties, because there was a lot [that] came out of the complaints; there was a lot of fear of management that if I say something, I am going to be penalised.[120]

117 Closed Submission 14, Esther Foundation, p. 2.
118 *ibid.*
119 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 8.
120 *ibid.*, p. 10.

4.5 Mr Lavater told us that he requested for this investigation to be undertaken due to Ms Lavater bullying senior staff, including himself.[121] The investigation was conducted by only three of the board members who were not related to the Lavaters or close personal friends. They found that both Rodney and Patricia Lavater had behaved in an 'inappropriate manner' and they were offered counselling and mediation.[122]

4.6 A grievance sub-committee had previously been established which included the new Executive Officer, Mrs Anina Findling, when she joined the board in 2019. Mrs Findling dealt with further complaints and then prepared 'a very condensed summary of the many, many complaints' to the board because 'the board did not ask for a comprehensive report.'[123]

4.7 When Mrs Findling was appointed as Chief Executive Officer in late 2019, the board told us that listening to complaints that emerged from former residents was 'very much' part of her role and one of the reasons for her appointment.[124] The board told us it was satisfied with the reports it received on those complaints and because they largely related to past staff and practices, 'we just assumed that it had been dealt with.' Had there been any indication that the complaints were 'just not going away' the board said it would have considered a different approach and offered to meet with them directly.[125]

> ***We very much felt that initially the first point of contact had to be the CEO because she could explain what changes she was making on the ground.***
>
> *- Mrs Annette Latto*

4.8 There is some discord between this evidence and evidence discussed further below—namely, that the organisation engaged a public relations consultant to assist with communicating Ms Lavater's exit from the Esther Foundation, and was also aware of an ongoing risk of complaints being escalated to the media. Neither of these is consistent with an assumption that the complaints had been adequately settled.

Patricia and Rodney Lavater's employment was terminated

4.9 In October 2019, Rodney Lavater was dismissed as the administrator of the Esther Foundation and terminated from his position on the board.[126] Mr Lavater told us that he walked away from the organisation after a 'very public breakdown' at the October 2018 Annual General Meeting and did not return, as he felt he had been mistreated.[127]

4.10 The circumstances surrounding Patricia Lavater's departure from the organisation were more complex. The board minutes record that after a new Chief Executive Officer was appointed in November 2019, Ms Lavater advised in December 2019 that she would be stepping down from all management duties 'to focus on the girls in the program that are

121 Mr Rodney Lavater, Former administrator, Esther Foundation, Email, 24 November 2022, p. 1.
122 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 10.
123 Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, p. 9.
124 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 8.
125 *ibid.*, p. 9.
126 Board meeting minutes, 10 October 2019.
127 Mr Rodney Lavater, Former administrator, Esther Foundation, Email, 24 November 2022, p. 1.

detoxifying.' The board considered that Ms Lavater may head up a new department titled 'recovery support', to report to the CEO.[128]

4.11 Ms Lavater then went on a period of leave from January 2020. At that time the board 'pretty much made it obvious' that her role was 'going to finish' and they would 'sort it out' while she was on leave. This decision was taken in response to 'staff behaviours that could not be reconciled.' However, when further complaints from former residents emerged during Ms Lavater's leave period, the board finalised its decision that Ms Lavater could no longer have any role within the organisation because 'if only half of those complaints were true', they 'could not risk any more issues like that.'[129]

4.12 Despite the board concluding that it was necessary to terminate Ms Lavater's employment, it was not prepared to publicly condemn Ms Lavater. Even after her departure, the organisation continued to try to involve and recognise Ms Lavater to some extent. A board member told us that they

> tried to be graceful in that exit because she had dedicated so much of her life to trying to help girls the best that she knew how. Whether or not that met standard is a different story, but that was her; she was very passionate about the care.[130]

4.13 For example, at the January 2020 board meeting the board agreed that given the 'ongoing investigation of outstanding complaints against her', it would be inappropriate for Ms Lavater to attend the upcoming strategic planning day. However, she was invited to attend breakfast to share her 'vision' for the future of the organisation.[131]

4.14 At the November 2020 board meeting, it was resolved that a commemorative plaque would be dedicated on the premises as a 'service recognition award' for Ms Lavater, and that Ms Lavater would be invited back for its unveiling and photographs.[132] A former staff member told us that this was a 'farce', and represented the board's 'head-in-the-sand mentality' and 'continual avoidance of difficult conversations and denial of how bad it was.'[133] It was later noted that this this would be presented at the November 2021 Annual General Meeting and that Ms Lavater would be given the option to take the plaque home.[134]

4.15 The board was also reluctant to censure Ms Lavater in the communications strategy that was formulated around her departure.

There were two different communications about Ms Lavater's departure from the Esther Foundation

4.16 After engaging a public relations consultant, Mercer PR, in January 2020, the organisation then helped Ms Lavater with an exit strategy when she returned from leave.[135] At the end of

128 Board meeting minutes, 12 December 2019.
129 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 12.
130 *ibid.*, p. 11.
131 Board meeting minutes, 23 January 2020.
132 Board meeting minutes, 25 November 2020.
133 Closed evidence.
134 Board meeting minutes, 25 November 2021.
135 Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, p. 2.

March 2020, Ms Lavater personally announced her departure from the organisation with two separate written communications—a former staff member told us that Ms Lavater 'insisted' on this,[136] although Ms Lavater said that this was the board's decision.[137] One was distributed internally, which included an acknowledgement of the complaints and 'mistakes and wrongs' that were done on her watch, and an apology to those who were hurt by her 'lack of sensitivity' or by actions that were 'not Christlike.'[138] Ms Lavater told us that this was because 'we realised that there were things that we could have done better and we realised that there were maybe people who were not happy with the way we had operated.'[139] The other communication simply announced her departure but did not refer to the complaints or acknowledge any wrongdoing because there was no need to 'air dirty linen.'[140]

4.17 In an email response to a complainant, a former staff member acknowledged that it would not have been 'helpful to the interests of the organisation as a whole to make supporters aware of problems that they weren't necessarily previously aware of.'[141] They told us while the Esther Foundation did not officially distribute Ms Lavater's apology, it was forwarded to the former residents who had made complaints at that stage, and the organisation did not seek to 'clamp it down' or restrict its informal distribution.[142] A board representative acknowledged that they 'copped some criticism' for not distributing Ms Lavater's apology more widely but 'it was deliberate not to put that out in the public arena' because they viewed it as primarily relating to the staff complaints.[143] They also told us that although they were not sure how well known the allegations against Ms Lavater were outside the organisation, they suspected that external stakeholders 'kind of knew' what had happened and would have seen earlier that a transition was taking place with the appointment of a new CEO.[144]

4.18 It was noted at the April 2020 board meeting that the public relations strategy had been 'successfully implemented.'[145] A former staff member told us that, on advice from the public relations consultant, the board had been prepared to make its own follow-up statement but this wasn't seen as necessary because the allegations died down and there were no further complaints or negative feedback to the announcement.[146]

4.19 This was not entirely the case. One former resident who had made a complaint responded immediately upon receiving the internal message with Ms Lavater's apology, and noted:

> Patricia may be leaving, but the fact that she is going with everyone's blessing, condoning all her past actions, means that the Esther Foundation condones these

136 Closed evidence.
137 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 4.
138 Closed evidence.
139 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 4.
140 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 12.
141 Closed evidence.
142 Closed evidence.
143 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, pp. 12-13.
144 *ibid.*
145 CEO Report for Board meeting, 16 April 2020.
146 Closed evidence.

> past actions… I cannot let such injustices and abuses go unheard. I cannot do so ethically.[147]

4.20 It is clear from this communication that the former resident was dissatisfied with the Esther Foundation's failure to publicly acknowledge the reasons for Ms Lavater's departure or denounce her. It isn't clear to us whether the board was made aware of this response, but it had been aware since early 2020 that there was a risk of complaints being escalated to the media.[148]

4.21 In mid-2020, the same former resident became aware that there had been separate internal and external messaging and wrote again to express her dissatisfaction. The board was made aware of this. However, it felt that having overhauled the organisation's staffing and procedures in response to the complaints, any further complaints from former residents were 'outside of our level to control' and 'the horse had long bolted.'[149]

4.22 In her correspondence to the organisation, the former resident tried to communicate that while it was obviously not in the Esther Foundation's interests for corporate sponsors to know about the complaints, it was in the sponsors' interests for them to know so they could choose whether to continue to involve themselves, and they had not been given that choice. She noted that 'it is absolutely in the interests of justice and fairness for people to not have their abuse swept under the carpet' and the organisation had 'benefitted from years of people in the community believing that these things did not occur.'[150]

4.23 She also acknowledged that while many changes had been made at the Esther Foundation in response to the complaints, former residents still felt silenced by the organisation's failure to acknowledge their experiences.

> … a group of us had finally found the strength, had finally reached the point of feeling able to speak out about our lives, to be honest and perhaps finally to become free. Not being allowed to speak truthfully about your life is a horrible and debilitating experience, it imprisons you forever…
>
> Now, you have reformed the program. This is a work of immense scope, one that must have been so hard…
>
> But because of this, we still can't speak. If your program is to survive, it requires our silence. Now, we're imprisoned again.
>
> Where is our justice?[151]

4.24 The Esther Foundation board made no public statement regarding the complaints and allegations until more emerged in the media in early 2022. At that stage, it acknowledged that harm had been caused in the past and it apologised 'sincerely and without reservation'. It also highlighted the significant changes it had undertaken in the previous two years,

147 Closed evidence.
148 Board meeting minutes, 23 January 2020; CEO Report for Board meeting, 13 February 2020.
149 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 13.
150 Closed evidence.
151 Closed evidence.

including parting company with the founder and former managing director, reorganising its programs, implementing strict quality, safety and best practice procedures, appointing new board members and engaging a new executive team and qualified personnel.[152]

4.25 Ultimately, the board would have considered the organisational risks in the communications strategy it chose to adopt around Ms Lavater's departure in 2020. How the board chose to manage these risks was a decision for them, and it is impossible for the Committee to predict whether there would have been a different result if the organisation had chosen to publicly acknowledge the earlier complaints and censure Ms Lavater when she left in 2020.

Finding 10

The Esther Foundation did not publicly acknowledge former residents' complaints and allegations, or offer an apology, until these emerged in the media in 2022.

The board did not view itself as accountable for the organisation's culture or the behaviour that was the subject of the complaints

4.26 In our opinion the board's strategy as outlined above, as well as its explanation to the inquiry regarding the complaints, also reflected that the board viewed itself as having limited responsibility for Ms Lavater's behaviour or the organisational culture and failings that allowed that behaviour to occur. The board sought to put itself at arms' length from the complaints against Ms Lavater and did not view itself as fully accountable for those, despite at least some occurring on their watch.

4.27 Certainly from 2020 onwards, the board focussed on improving the organisational culture of the Esther Foundation. When the board reviewed its policies in early 2020, it was suggested that a new 'culture' policy be introduced in recognition of the fact that 'high profile failures of organisational culture in the past decade have put legal pressure on Boards to define and monitor the culture of their organisation.'[153] The new policy was adopted in May 2020 and explicitly noted the board's responsibility to define the organisation's desired culture and monitor the culture as 'seen in the actions and relationships of members of the Esther community, including those interactions that are 'below the surface.''[154] At the 2021 strategic planning day, the board recognised that 'the culture of the Foundation must start from the top, with the Board modelling the desired culture.' It was agreed that the previous culture under former management had featured fear, shame, chaos, no trust, 'trauma from top to bottom' and minimal board-organisation interaction.[155]

4.28 Despite this recognition, and a general acceptance by the board that the complaints were 'probably true' or 'possibly happened', in its evidence to the inquiry the board repeatedly distanced itself from the complaints and allegations on the basis that:

- they didn't witness the behaviour or know about it at the time

152 Esther Foundation, *Statement from the Board of the Esther Foundation*, 10 March 2022, accessed 20 April 2022, <website no longer active>.
153 Revision of Board Policies, January 2020 (included in board meeting pack for 23 January 2020 meeting).
154 Esther Foundation, Culture Policy, 27 May 2020.
155 2021 Strategic Planning Day notes.

- it pre-dated their involvement with the organisation, or
- it related to past practice.[156]

4.29 While this may well have been true, the inadequacy of this attitude to accountability was highlighted to us by a former staff member:

> I know that directors, post-royal commissions, cannot say, "We didn't know." It is not good enough to say, "We didn't know." You have a duty of care and diligence to know.[157]

Finding 11

The board's response to the complaints and allegations reflected that it did not view itself as accountable for the unacceptable practices that had occurred, or the organisation's culture that had allowed these practices to occur.

The board was renewed although the Chairperson remained

4.30 As discussed in Chapter 3, the Esther Foundation had significant difficulty attracting new, independent members with appropriate skills. However, this changed from late 2019 when the board composition was almost completely renewed through Mrs Findling's networks. The exception to this was the board Chairperson, Mrs Latto, who held that position from 2015 until the organisation went into voluntary administration in 2022.[158]

4.31 The board renewal brought a more professional and strategic focus, and a more appropriate separation of the organisation's governance and operations. Representation of operational staff was reduced to just the ex-officio attendance of the Chief Executive Officer, whereas previously half the board had been comprised of operational staff.

4.32 As part of a board review in early 2021, board leadership and succession planning was identified as an issue for priority discussion.[159] The Committee received some evidence that this was due to performance issues.[160] We were also told that there was a poor public perception and risk to the organisation in the Chairperson remaining in her position after 2019, and that she should have resigned when the complaints and allegations came to light.[161] Again, this was ultimately a matter for the Chairperson and the board. However, in our opinion, it reduced the credibility of the Esther Foundation's response to the complaints and allegations.

156 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, pp. 12, 16, 19; Mr Jeroen Bruins, former Deputy Chairperson, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 16.
157 Closed evidence.
158 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 2.
159 Summary of Board Self-Review (2021 Strategic Planning documents); Board Review Items for Discussion (included in board meeting pack for 25 February 2021 meeting).
160 Closed evidence.
161 Closed evidence.

Finding 12

The board Chairperson remained in her position, despite the fact that unacceptable practices had occurred during the period of her service. This reduced the credibility of the organisation's response to the complaints and allegations.

A more structured program was adopted

4.33 From early 2020, the Esther Foundation adopted 'Celebrate Recovery' as part of its program offering, which is a Christian 12-step program similar to Alcoholics Anonymous and other recovery models. It was noted that 'this structure is along the same lines of other trusted rehabilitation methods/program structures'[162] and introducing it 'helped strengthen our credibility with the government and corporate stakeholders.'[163]

4.34 A six-stage program was also implemented, which was noted to be 'a landmark moment' because it 'sets out clear guidelines of what is expected of the participants behaviourally, practically and emotionally in each stage in order to progress to the next stage'.[164] This was accompanied by a 'behaviours and consequences chart' to help participants 'develop the self-awareness and self-regulation of their emotions and behaviours.'[165]

Policies and processes were improved, and the organisation was restructured

4.35 From mid-2019, the organisation began overhauling its operational processes under the leadership of the new Executive Officer, Mrs Anina Findling, who later became the Chief Executive Officer. This included new back end compliance and risk management systems and an upgraded IT platform to accommodate online data management. Mrs Findling told us that this was 'overwhelming with magnitude' and a 'huge undertaking'.[166]

4.36 Another part of this was an organisational restructure, which was approved by the board in late 2019. It was noted in early 2020 that there were still 'constant personal and relational crises' happening with staff; gradually, more appropriately qualified staff were hired to fill newly created senior leadership and management roles. The board told us that this was 'quite a difficult transition period. Moving on the founder and a cohort of staff that were very attached to her; it was a pretty difficult job.'[167]

4.37 The changes were communicated broadly 'to reassure people that issues have been heard and are being addressed.'[168] A newsletter from the CEO in early 2020 noted that 'there was a lot of "catch-up" work to be done to establish governance and management structures suited to the growing size and expectations of our community'.[169]

4.38 There was also a full revision of board and organisational policies and procedures, and employee job descriptions. The Committee received copies of the Esther Foundation's policy

162 CEO Report (included in board meeting pack for 13 February 2020 meeting).
163 Esther Foundation, Annual Report 2019/2020, p. 21.
164 *ibid.*, p. 18.
165 *ibid.*, p. 11.
166 Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, p. 3.
167 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 6.
168 CEO Report (included in board meeting pack for 13 February 2020 meeting).
169 Closed evidence.

and procedure documents from both pre- and post-2019. There is a stark contrast in these two sets of documents, with the revised policies being significantly more comprehensive and professional. While this alone does not guarantee that unacceptable practices would not have occurred, it demonstrates the considerable effort and resources that the organisation dedicated to improving its professionalism in response to the complaints and allegations.

4.39 The inquiry received evidence from two medical practitioners who provided services to the Esther Foundation, who both confirmed an improvement in professionalism from 2020 onwards. This included more comprehensive written policies and procedures, including for outside service providers, improved consultation facilities, and better coordination and liaison between medical practitioners, resulting in more holistic care.[170]

4.40 In early 2020, the CEO required all counsellors and therapists to present copies of their current registrations and insurances. This resulted in one long-standing counsellor being asked to discontinue providing services to Esther Foundation residents on the basis that he was no longer registered with the Psychology Board of Australia and did not plan to re-register.[171]

4.41 In August 2021, the board also resolved to increase the minimum age of residents from 14 to 18 years. This was partly in recognition of difficulties the organisation had in meeting educational and duty of care requirements for younger residents.[172]

Internal and external feedback channels were embedded

4.42 Throughout the revised policy and procedure documents, there was additional focus on promoting a common responsibility across the organisation around reporting improper conduct, and creating a safe environment for this to occur. These expectations, and documented grievance processes, were promoted on the Esther Foundation website, in staff training and in employee and volunteer handbooks.

4.43 We were told that no complainant ever asked the board about escalating their complaint beyond the organisation although, had this occurred, they would not have discouraged it.[173] As is discussed elsewhere in this report, aside from reporting criminal matters to the police, there were few external agencies that were empowered to receive and investigate a complaint against the Esther Foundation. Where complaints were made to external organisations, little follow-up or investigation occurred.

4.44 In March 2022, in response to the media reporting of complaints, the Board stated that it had resolved to appoint 'an independent and suitably qualified person to manage a dedicated complaints process'.[174] However, this was not progressed once the organisation entered voluntary administration.

170 Closed evidence.
171 CEO Report (included in board meeting pack for 13 February 2020 meeting).
172 Board meeting minutes, 26 August 2021.
173 Closed Submission 60, Mrs Anina Findling, p. 4.
174 Esther Foundation, *Statement from the Board of the Esther Foundation*, 10 March 2022, accessed 20 April 2022, <website no longer active>.

Some professional support was offered to complainants

4.45 Immediately following Ms Lavater's departure, the organisation brought in a senior staff chaplain to offer pastoral support and 'get them feeling safe to speak, because they had been suppressed and unheard for so long.'[175] We were also told that $500 worth of professional counselling sessions were offered to previous or current staff and residents, but only one former staff member accepted that offer.[176] A former resident told us that professional counselling support was only ever offered informally and she queried the organisation's capacity to fund it to the necessary extent.[177]

4.46 In April 2022, the organisation announced that an initial three sessions of counselling through an independent, secular service would be would be offered free to former residents.[178]

Religious requirements and practices were changed

4.47 Although the requirement to attend Sunday church services remained, from late 2019 residents started to visit a wider variety of Christian churches throughout the city to 'build relationships' and an 'accountability network' rather than 'doing our internal nepotistic approach to religion.'[179] A former staff member told us that this was received with 'great relief' by staff who had 'experienced trauma' in the services led by Ms Lavater.[180]

4.48 The board also gave evidence that they were 'probably starting to move away' from the religious requirements previously imposed on staff and board members.[181] The organisation also became concerned that residents had a choice when it came to participating in the religious aspects of the program.[182]

> ***I guess that is where we were trying to move the organisation to—to be faith informed, but not coerced.***
>
> *- Mrs Annette Latto*

4.49 From March 2020, board members, staff, volunteers and residents were required to sign a Statement of Faith, or an acknowledgement of this statement. Although the acknowledgement stated that volunteers and residents would 'never be compelled to believe', they were required to accept that 'personal comments which oppose the Statement of Faith principles would bring confusion, therefore we respectfully ask you to not voice these with our participants or on Foundation premises.'[183] The board and former interim CEO explained this as 'the same context as if you took your kids to a faith-based school'[184]—'respecting our values and respecting how we operate'[185] or 'an agreement not

175 Closed evidence.
176 Closed Submission 60, Mrs Anina Findling, p. 4.
177 Closed evidence.
178 Esther Foundation, *Statement from the Esther Foundation*, 20 April 2022, accessed 20 April 2022, <website no longer active>.
179 Closed evidence.
180 Closed evidence.
181 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 7.
182 *ibid.*, p. 18.
183 Acknowledgement of the Esther Foundation Statement of Faith, 5 March 2020.
184 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 19.
185 Mr Jeroen Bruins, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 19.

to disparage the organisation or how it operates.'[186] However, the board was clear that this would not override an expectation that people would report 'inappropriate' or 'wrong' practice.[187]

Cultural awareness was identified as an area for improvement

4.50 The former CEO, Mrs Findling, told us that one of her objectives with the Federal grant funding was to increase the education, awareness and proportion of Indigenous participants in the program and 'to really help them to embrace and celebrate aspects of their culture', which was 'the complete opposite to what was happening before.'[188] 'Cross-cultural awareness' was included as a performance indicator in the organisation's activity work plan, which was prepared as a grant funding requirement. This was to be measured by increasing the number of Indigenous and cross-cultural resident numbers, and embedding awareness programs into the curriculum. An Indigenous staff member was assisting with this, as well as the Foundation for Indigenous Sustainable Health.[189]

Accreditation was identified as essential

4.51 From early 2021, the board began to consider whether the Esther Foundation would be required to seek accreditation in compliance with the National Quality Framework for Drug and Alcohol Treatment Services. This framework is discussed in more detail in Chapters 5 & 6.

4.52 The Esther Foundation began by considering whether it was necessary to pursue accreditation and what would happen if it didn't.[190] By May 2021, a full report had been prepared for the board seeking approval to commence the accreditation process. The Western Australian Network of Alcohol and Other Drug Agencies (WANADA) Alcohol and other Drug and Human Services Standard was recommended as the most appropriate accreditation framework.

4.53 The report noted that the organisation would be open to some obvious risks if it did not pursue accreditation, including:

- ineligibility for state and federal government funding—the greatest risk in this regard would be losing current federal grant funding
- missing out on referrals from government agencies and other key players
- weakened 'brand and image'—accreditation was noted to be 'an important step in getting the recognition we need as a specialist and trusted provider in this area.'[191]

186 Mr Philip Sparrow, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 20.
187 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 20.
188 Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, p. 7.
189 Esther Foundation Activity Work Plan and Budget (included in board meeting pack for 23 January 2020 meeting); Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, p. 7.
190 CEO Report (included in board meeting pack for 25 March 2021 meeting).
191 Accreditation Board Report (included in board meeting pack for 27 May 2021 meeting).

4.54 It was noted that the religious component of the Esther Foundation program was not an area of concern to WANADA and diversity in the sector was encouraged.

4.55 The board agreed with the report's recommendations to enter the accreditation process, apply for WANADA membership, engage with the accreditation body, and commence the self-assessment process within the WANADA framework. It was noted that accreditation was an unbudgeted item and alternative funding would be required.[192]

> ***We wanted to be an accredited body that actually was recognised for the work we were doing and not continue to run a mum-and-dad organisation.***
>
> *- Mrs Annette Latto*

4.56 The board told us that seeking accreditation was 'one way we would move on from past practice.'[193] However, it is unclear how much progress was made towards this goal. At the November 2021 board meeting, it requested that an update on the progress towards accreditation be provided at the January 2022 board meeting but the inquiry did not receive a copy of the minutes of that meeting. WANADA gave evidence that they had first engaged with the Esther Foundation about accreditation in early 2020 but they were not aware of the Esther Foundation progressing to register their intent to become certified with the certification body.[194]

Finding 13

From 2020 onwards, the Esther Foundation devoted significant resources and effort to improving its governance, professionalism and quality. This was in response to the complaints, and in recognition that the longer term sustainability of the organisation depended on it.

Complaints emerged in the media in 2022 and the Esther Foundation closed

4.57 The board told us that the emergence and extent of the complaints and allegations in early 2022 was 'not expected' and it only learned of the details through the media and what was reported in Parliament. It was not in a position to formally respond as no formal complaints at that time were made directly to the organisation.[195] It said that 'the extent and depth' of the complaints were 'deeply troubling' and 'completely at odds with current operations and experience.'[196]

4.58 In response to the media reporting, the Esther Foundation took the following actions:

- ceased accepting new referrals, to prioritise resources to existing residents
- issued a statement offering counselling support (as discussed above)
- assessed and scoped the likelihood of legal claims that may arise, and made contingency

192 Board meeting minutes, 27 May 2021.
193 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 20.
194 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 14.
195 Closed Submission 14, Esther Foundation, p. 3.
196 *ibid.*, p. 1.

- worked closely with the Department of Communities and potential service providers to ensure an appropriate and professional organisation could take over operations, staff and assets
- committed to assist this inquiry, including provision of requested documents.[197]

4.59 Ultimately, the reputational damage from the media reporting led to withdrawal of funding support and the Esther Foundation entered voluntary administration in April 2022. In assessing the ongoing viability of the organisation, the board told us that it not only considered its financial position but also whether it should continue to operate in light of the 'obvious distress' of some past participants. It balanced this consideration against the needs of current residents, and the success and positive experiences of many former residents.[198]

It was not purely around we are going to run out of money. It was around what is the best outcome for people.

- Mrs Annette Latto

4.60 The board reflected that it was extremely sad that the Esther Foundation had to close down, given the immense amount of work that had been put into reforming the organisation and program since 2020.[199] However, it hoped that better outcomes could be achieved for rehabilitation facilities in the future, and complainants would feel validated and 'some justice or truth will become clear' to provide closure.[200]

197 Closed Submission 14, Esther Foundation, p. 2.
198 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 21.
199 Mr Jeroen Bruins, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 16.
200 *ibid.*, p. 21; Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 21.

Chapter 5

Gaps in existing legislative and regulatory frameworks

5.1 When the complaints about the Esther Foundation arose publicly, it was quickly established that existing legislative and regulatory frameworks had not captured the Esther Foundation to allow for oversight of its operations. It was in this context that the Committee was tasked with examining current regulatory and legislative frameworks 'to understand whether there are ways to improve existing provisions or there are gaps that might need to be addressed.'[201]

5.2 Based on the services that the Esther Foundation promoted itself as providing, the Committee examined the existing legislative and regulatory frameworks in the following areas:

- private healthcare facilities
- mental health services
- AOD treatment services.

5.3 In summary, the existing safety and quality mechanisms for private healthcare facilities, mental health or AOD treatment services did not capture the Esther Foundation. Additionally, currently emerging regulatory mechanisms for AOD treatment services that would apply to the Foundation were not yet enforceable. This chapter discusses the limitations of these mechanisms.

Private healthcare facilities

5.4 The Department of Health's Licensing and Accreditation Regulatory Unit (LARU) administers the *Private Hospitals and Health Services Act 1927* (the PHHS Act), which provides for the control and regulation of private healthcare facilities. Three 'pillars' in the PHHS Act support safe patient care:[202]

1. Legislating barriers to entering the private health industry

   A person is prohibited from conducting or managing a private health facility unless they hold a licence. A licence can only be issued if the Department of Health is satisfied that the licence holder, premises and arrangements for management, staffing and equipment are suitable. Licensing also mandates accreditation to a particular set of standards set by the Australian Commission on Safety and Quality in Health Care.[203]

201 The Hon. Simone McGurk MLA, Minister for Child Protection, Women's Interests; and Community Services, Legislative Assembly, *Hansard*, 7 April 2022, p. 1784.
202 Submission 65, Department of Health, p. 2.
203 Dr Christina Bertilone, A/Executive Director, Patient Safety and Clinical Quality, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 1.

2. Allowing full powers of access and inspection to assess compliance

   Licences expire annually and are only renewed when the Department of Health is satisfied that the relevant guidelines and standards are again assessed as met. Higher risk facilities are inspected more regularly.

3. Allowing for steps to be taken to address non-compliance

   This includes placing conditions on a licence, suspending or ultimately cancelling a licence, forcing closure of a health facility.

The PHHS Act applies to accommodation-based mental health services

5.5 The terms of reference for this inquiry referred to facilities not covered by the definition of 'health service' or 'hospital' in the PHHS Act. Both of these terms are defined by reference to the *Health Services Act 2016*.

5.6 The title of the PHHS Act naturally implies that it governs both private 'hospitals' and 'health services.' However, there are no specific provisions in the PHHS Act that refer to a 'health service', which is defined broadly as 'a service for maintaining, improving, restoring or managing people's physical and mental health and wellbeing.'[204] Therefore, while the Esther Foundation may have fit the definition of a 'health service', that term has no practical application in the PHHS Act.

5.7 The Department of Health identified that accommodation-based mental health services in WA are, as a general principle, regulated by the statutory framework for 'private psychiatric hostels'.[205] The PHHS Act establishes a licensing scheme for the control and regulation of private health facilities which meet the legislative definition of 'hospital' or 'private psychiatric hostel'. The Esther Foundation would have had to meet one of these definitions in order to be subject to the regulatory scheme in the PHHS Act. Evidence to the inquiry has consistently suggested that the closest possible definition was as a 'private psychiatric hostel.' Given this, Chapters 5 & 6 will focus on the PHHS Act only insofar as it relates to these facilities.

5.8 Ultimately, it proved impossible to determine whether the Esther Foundation met the definition of a 'private psychiatric hostel.' This was not only because the definition is unclear, but also because LARU had no power to investigate whether the definition was applicable.

Finding 14

The *Private Hospitals and Health Services Act 1927* regulates accommodation-based mental health services that meet the definition of 'private psychiatric hostel.'

204 *Health Services Act 2016*, s. 7(1).
205 Submission 65, Department of Health, p. 1.

There are limitations in regulating private psychiatric hostels through the PHHS Act

5.9 Evidence to the inquiry identified that there are three problematic limitations to the PHHS Act:

- some of the definitions are unclear
- there are no powers to inspect or audit unlicensed facilities to check if they meet the statutory definitions and require a licence
- key content is contained within the PHHS Act rather than the associated regulations, which limits the ability to respond to emerging issues.

5.10 Each of these limitations is discussed in further detail below.

The definition of a private psychiatric hostel in the PHHS Act is not clear

5.11 Under the PHHS Act, the definition for a licensable private psychiatric hostel is:

> **Private psychiatric hostel** means private premises in which 3 or more persons who—
>
> (a) are socially dependent because of mental illness; and
>
> (b) are not members of the family of the proprietor of the premises,
>
> reside and are treated or cared for.[206]

5.12 'Mental illness' is defined by reference to the *Mental Health Act 2014* as a condition that

> (a) is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and
>
> (b) significantly impairs (temporarily or permanently) the person's judgment or behaviour.[207]

5.13 Various personal circumstances are listed as specific exclusions from this definition, including that a person uses alcohol or other drugs or engages in anti-social behaviour.[208]

5.14 The terms 'socially dependent because of mental illness' and 'reside' are not defined in legislation and the Department of Health told the Committee that these have been a source of confusion and debate.[209] The Department of Health has previously sought legal advice in relation to these terms and the State Solicitor's Office advised:

> **'socially dependent because of mental illness'** – someone who depends on others for assistance/company because of their mental illness.
>
> **'reside'** – takes the ordinary meaning 'to dwell permanently or for a considerable time, have one's abode for a time', there must be some assumption of permanence, some degree of continuity. 28 days was found to be insufficient but

206 *Private Hospitals and Health Services Act 1927*, s. 3.
207 *Mental Health Act 2014*, s. 6.
208 *ibid.*, s. 6(2).
209 Submission 65, Department of Health, p. 1.

> transitional accommodation for several months (up to a year) while not permanent, would be their home for the time being and meet the definition of reside.'[210]

5.15 Other legal advice obtained by the Department of Health suggests that one of the key features of a 'private psychiatric hostel' is that it is an accommodation-based service providing sub-acute care and supervisory services only, rather than a treatment-based service that is provided by other classes of private health facilities. The same advice suggests that the term 'private psychiatric hostel' is out of date with current terminology in the sector, and unnecessary and unclear, given that no psychiatric treatment is provided.[211]

5.16 Given this advice, the Department of Health suggested that the definition of 'private psychiatric hostel' should be amended to make it clearer, contemporary and consistent with other legislation.[212]

Finding 15

The definition of a 'private psychiatric hostel' in the *Private Hospitals and Health Services Act 1927* is outdated and unclear.

There are no powers under the PHHS Act to investigate whether a facility is required to be licensed

5.17 The PHHS Act does not give LARU powers to investigate facilities that may require licensing. LARU relies on facilities self-identifying as falling under the remit of the PHHS Act. It cannot enforce licensing requirements on a facility if the facility does not identify itself as meeting the definition of a 'private psychiatric hostel'.

5.18 Although it is an offence to operate an unlicensed facility, the Department of Health told the Committee that:

> …it is very difficult for us to do anything about that. Again, we have legal advice on that point and we are able to ask legal to bring a case, a prosecution, for us, but they would need evidence to base that prosecution on and we do not have the ability to gather the evidence, so we have never used that provision.[213]

5.19 The Mental Health Commission also recognises the limitations of LARU's investigative powers and told the Committee that the 'lack of powers within the PHHS Act promotes a self-regulatory model within mental health service delivery.'[214]

Finding 16

The limited investigatory and enforcement powers in the *Private Hospitals and Health Services Act 1927* promote a self-regulatory model within mental health service delivery, which is unsatisfactory.

210 *ibid.*
211 MinterEllison, Letter to Mrs Vanessa MacDonald, 13 May 2022, pp. 3, 5.
212 Mrs Vanessa MacDonald, Principal Consultant, Licensing and Accreditation Regulatory Unit, Department of Health, *Transcript of Evidence*, 10 August 2022, pp. 5-6.
213 *ibid.*, p. 7.
214 Submission 66, Mental Health Commission, p. 2.

The Esther Foundation did not identify itself as a private psychiatric hostel

5.20 The Department of Health told the Committee how the limitations of the PHHS Act were demonstrated in the case of the Esther Foundation:

> The Esther Foundation was not licensed under the PHHS Act and there are no powers under the PHHS Act to investigate whether a health service such as the Esther Foundation is required to be licensed nor to enforce the requirement to be licensed, should they choose not to be licensed.[215]

5.21 In the absence of powers for LARU to investigate facilities that appear as though they may meet the requirement to be licensed in the PHHS Act, LARU has internal processes for looking at such facilities:

> …we have a policy within LARU for looking at potentially unlicensed facilities, as Esther Foundation was. Twice a year, we write to all our stakeholders. That includes people like the Mental Health Advocacy Service and health services providers, and we ask whether they are aware of any facilities that might be operating as potentially unlicensed facilities. Then we have a process of contacting them to ask for further information about what they are providing and what their cohort looks like, and ask them to determine whether they have a need to be licensed under the act. We provide them with a definition and ask them to make an assessment to determine whether they meet that definition.[216]

5.22 The Department of Health told the Committee that LARU performed this process with regard to the Esther Foundation in late 2018, following notification from the Mental Health Commission in response to concerns that had been reported about the Esther Foundation.[217]

> On 23 November 2018, LARU wrote to the Esther Foundation following notification by the Mental Health Commission that they suspected there might be an unlicensed facility. In our letter we provided the definition of a private psychiatric hostel and requested that they consider that definition and reply to us as to whether they needed to be licensed. On 29 November 2018, we received an email from… the administrator of Esther Foundation, stating that no participants at Esther Foundation were socially dependent. Actually, he was quite angry about the inquiry, and still we said we would really appreciate their response formally to our request for a statutory declaration. On 3 December 2018, we received a statutory declaration signed by the chairperson of Esther Foundation… and she again reiterated that Esther Foundation did not meet the definition of a private psychiatric hostel, stating that it did not provide services for people who are socially dependent, rather girls and women with mental health issues, including

215 Submission 65, Department of Health, p. 1.
216 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, pp. 4-5.
217 Additional information arising from hearing with the Mental Health Commission on 10 August 2022, received 6 September 2022.

> depression, anxiety, self-harm and eating disorders. As I mentioned, we, having received that confirmation from this facility, had no further powers to act.[218]

5.23 The former Board Chairperson told the Committee that they received a letter from LARU, asking whether the Esther Foundation fit the criteria for licensing under the PHHS Act:

> I think the original letter from the department was around "we have been advised that you might be providing hospital services", which is very much not what we were providing. So, we did look into what that definition was, and definitely not, it was never the intent that we were providing that level of service.[219]

5.24 The Department of Health could take no further action to determine whether the facility was required to be licensed and it closed the matter:

> … their interpretation was that they did not have people who met that definition and, therefore, they fell outside of the definition of a licensable facility…that is where it stops for us at LARU. We do not have the powers under the act to make any further inquiries or to require any information to be provided to us. We cannot require people who might be operating an unlicensed facility to give us any information or to allow us access to the facility to assess for ourselves.[220]

5.25 The absence of powers of inspection is a gap identified by the Department of Health, and one that it wants rectified.[221]

> That is a high priority for change for us to get those powers, so that if we make inquiries and we are not satisfied with the responses, we would then be able to go further to either require a statutory declaration or to actually go to the premises and perhaps speak to the cohort who are there or the staff and to investigate more fully to determine if they meet our definition and therefore require licensing. That is high priority for us.[222]

5.26 The Mental Health Commission agreed that it was unsatisfactory that LARU had no powers to pursue these matters further:

> '…there has to be a strengthening of mechanisms so that one cannot simply say, "Well, sorry that is not me", sign a statutory declaration and be left to their own devices.'[223]

Finding 17

Despite receiving information that led it to suspect the Esther Foundation may have been operating as an unlicensed facility, it was not possible for the Department of Health to determine whether the Esther Foundation required licensing under the *Private Hospitals and Health Services Act 1927* because the Esther Foundation did not identify itself as such.

218 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 5.
219 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 3.
220 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, pp. 4-5.
221 *ibid.*, p. 7.
222 *ibid.*, pp. 4-5.
223 Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 8.

Mental health services

5.27 The *Mental Health Act 2014* defines a 'mental health service' as including hospitals that provide treatment or care to people who have or may have a mental illness, and community mental health services. A 'community mental health service' means a service that conducts assessments or examinations for the purposes of the Act or provides treatment in the community (but does not include the private practice of a medical practitioner or other mental health professional).[224] Private psychiatric hostels are expressly excluded from the definition of 'mental health service', although they are specifically designated elsewhere in the Act as being a 'mental health service' for the purpose of falling under the responsibility of the Chief Psychiatrist of Western Australia.[225]

5.28 The Chief Psychiatrist of Western Australia has statutory responsibility for overseeing the treatment and care of a range of users of mental health services, pursuant to the *Mental Health Act 2014*. This responsibility is discharged by publishing a set of standards for treatment and care provided by mental health services, and overseeing compliance with those standards. All services defined as a 'mental health service' must comply with the National Standards for Mental Health Services (NSMHS) and the Chief Psychiatrist's Standards for Clinical Care.[226]

Regulation of private mental health services is limited to funded or licensed services

5.29 The Mental Health Commission is not a regulator of any services.[227] However, in procuring mental health services, the MHC requires that service providers obtain and maintain accreditation against the NSMHS through a recognised certification body. Re-certification is expected every three years before expiration of the previous accreditation. However, there is no power to compel service providers to adhere to the NSMHS if they do not receive government funding.[228]

5.30 Outside of funding arrangements, regulation of mental health services is limited to accommodation-based mental health services that are licensed as private psychiatric hostels under the PHHS Act. When the MHC procures mental health services that meet the definition of a private psychiatric hospital, the requirement to be licensed through LARU is included in any tender requests.[229] LARU maintains updated information regarding which licensed private psychiatric hostels are in scope for monitoring by the Office of the Chief Psychiatrist.[230] There is no regulator for accommodation-based mental health services that fall outside LARU's jurisdiction.

224 *Mental Health Act 2014*, s. 4.
225 *ibid.*, s. 507.
226 Office of the Chief Psychiatrist, *National Standards for Mental Health Services 2010*, accessed 29 July 2022, <https://www.chiefpsychiatrist.wa.gov.au/>.
227 Submission 66, Mental Health Commission, p. 2.
228 Submission 58, WANADA & WAAMH, p. 5.
229 Submission 66, Mental Health Commission, p. 1.
230 Submission 58, WANADA & WAAMH, p. 14.

5.31 We received no evidence on whether the Esther Foundation would have fallen within the definition of 'mental health service' for the purposes of the *Mental Health Act 2014*. However, even if it did fit this definition, there was no regulatory mechanism which would have captured it. It did not receive any WA Government funding for its operations nor was it licensed as a private psychiatric hostel. Therefore, there was no regulatory oversight by either the Mental Health Commission, the Office of the Chief Psychiatrist or LARU (see case study).

Case study: 2018 complaint to the Mental Health Commission about the Esther Foundation

In November 2018, a former resident of the Esther Foundation contacted the Mental Health Commission via its website. She had been sent there at 15 years of age to receive treatment for anxiety and suicidal ideation. The former resident reported experiencing and witnessing disturbing and distressing treatment, including observing criminal activity. She did not want to make a formal complaint directly to the Esther Foundation but did want to raise her concerns.

The Mental Health Commission advised that it did not directly fund the Esther Foundation but would contact the Department of Health's Licensing and Accreditation Regulatory Unit (LARU) to investigate and determine if the Esther Foundation fell under the definition of a 'private psychiatric hostel' and required licensing. The former resident was also referred to a number of support and advocacy services that could assist her directly.

The Mental Health Commission wrote to LARU asking for the matter to be investigated. LARU later responded that it had received a statutory declaration stating the Esther Foundation did not meet the definition of a 'private psychiatric hostel' and had therefore closed the matter.

Source: Additional information arising from hearing with the Mental Health Commission on 10 August 2022, received 6 September 2022.

Finding 18

Mental health services that are not private psychiatric hostels and receive no government funding are not captured within existing regulatory frameworks.

Finding 19

As an unfunded and unlicensed service, the accountability requirements that apply to mental health services were not enforceable against the Esther Foundation.

AOD treatment services

5.32 The National Treatment Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029 defines AOD treatment as:

> Structured health interventions delivered to individuals (by themselves, with their families, and/or in groups) to reduce the harms from alcohol, tobacco, prescribed medications or other drugs and improve health, social and emotional wellbeing.

5.33 There is no legislative framework for oversight of AOD services in Western Australia, as there is in relation to some mental health services. However, the AOD sector has a significant history of investment in continual quality improvement, supporting organisations to deliver

safe, evidenced and accountable services. This has been largely driven and led by WANADA as the peak body.[231]

5.34 Non-government AOD treatment providers are essentially left to self-regulate. Other quality standards and guidelines exist within the AOD sector to encourage continuous quality improvement. However, certification or accreditation against these standards is entirely voluntary.

Regulation of AOD treatment services is limited to funded services

5.35 Regulation of AOD treatment services is even more limited than mental health services. Funding arrangements are the only mechanism through which requirements can be imposed around quality and safety. LARU does not license AOD treatment services or residential rehabilitation facilities. An organisation providing both mental health and AOD services could technically require licensing although, as discussed above, the definition in the PHHS Act is difficult to determine without a full examination of the types of services being offered.[232] The Mental Health Commission told us that it is of 'great concern' that private psychiatric hostels and residential AOD rehabilitation facilities are regulated in different ways, given the similar vulnerability and complex needs of their clients, and the frequent overlap of mental health and AOD issues.[233]

5.36 The Esther Foundation was not funded by the WA Government to provide AOD treatment services, so it was not required to demonstrate compliance with any sector-specific quality and safety standards.

Finding 20

Non-government alcohol and other drug treatment services are only regulated through funding arrangements. Where there are no funding arrangements, there is no regulation or mechanism for enforcing compliance with quality standards for treatment and care.

Finding 21

The Esther Foundation was not funded by the WA Government to provide alcohol and other drug treatment services, and so it was not required to comply with relevant AOD quality and safety standards.

Lack of regulation of private AOD treatment services is a long-standing problem

5.37 Professor Nicole Lee, an expert consultant, told the Committee that the AOD treatment sector has raised concerns about the lack of regulation for 'several decades':[234]

> The problems that service users and their families experience with organisations like the Esther Foundation has a direct link to the lack of regulation of the private alcohol and drug sector, and I think it is one of the biggest problems that we

231 Submission 58, WANADA & WAAMH, p. 3.
232 Submission 66, Mental Health Commission, p. 1.
233 Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 3.
234 Submission 33, Professor Nicole Lee, p. 1.

currently face in the sector. It is not a recent issue, but it is an urgent one that needs to be resolved.[235]

5.38 Similarly, WANADA told us that they have been calling for regulation of the services not funded by government 'for a very long time, to ensure accountability.'[236]

A mandatory, nationally consistent approach to safety and quality in AOD treatment services has recently emerged

5.39 The absence of regulation in the AOD treatment sector is not unique to WA—nationally, efforts have been made toward quality improvement of AOD treatment services through the implementation of National Quality Framework for Drug and Alcohol Treatment Services (NQF).

5.40 The NQF aims to set a nationally consistent quality benchmark which consumers can expect from treatment providers.[237] It has been commissioned in response to federal inquiry recommendations and policy commitments which recognised the importance of quality service delivery and public accountability in the sector.[238] It notes that AOD treatment in Australia is provided by a variety of organisations with multiple funding sources, which creates challenges in ensuring customers receive value for money and client-focused treatment, including evidence-informed practice. Individuals and families seeking AOD treatment are often in crisis and can be vulnerable to accepting poor quality services that are unlikely to produce good outcomes. Existing quality mechanisms are variable and do not equally apply across all treatment service providers. There is no consistent approach to ensure minimum quality standards and quality improvement in the AOD treatment system.[239]

5.41 The NQF was endorsed by federal, state and territory ministers at the Ministerial Drug and Alcohol Forum in June 2018. Following a transition period, all alcohol and other drug treatment providers, irrespective of funding source, will be required to obtain and maintain accreditation against one of eight recognised accreditation standards from 29 November 2022. This is intended to be communicated and enforced either through:

- Contractual arrangements – for service providers receiving government funding, NQF requirements will be enforced through funding/service agreement mechanisms
- Jurisdictional arrangements – for service providers not receiving government funding, NQF requirements will be enforced through regulatory or other processes set by jurisdictions as appropriate, to ensure the NQF is applicable to local circumstances.[240]

5.42 The Mental Health Commission already requires all AOD treatment services receiving government funding to comply with the NQF and maintain accreditation. WANADA has also

235 Professor Nicole Lee, Expert Consultant, 360edge, *Transcript of Evidence*, 3 August 2022, p. 1.
236 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 17 August 2022, p. 1.
237 Department of Health, *National Quality Framework for Drug and Alcohol Treatment Services*, Commonwealth of Australia, Canberra, 2018, p. 5.
238 Submission 58, WANADA & WAAMH, p. 4.
239 Department of Health, *National Quality Framework for Drug and Alcohol Treatment Services*, Commonwealth of Australia, Canberra, 2018, p. 5.
240 *ibid.*, p. 7.

worked with other government agencies that fund AOD treatment services, such as the Department of Justice and WA Primary Health Alliance, regarding the requirement to comply with the NQF by November 2022.[241] However, there are currently no legislative or regulatory measures available in Western Australia to enforce the NQF requirements for services that are not government funded.

Finding 22

The National Quality Framework for Drug and Alcohol Treatment Services requires all alcohol and other drug treatment providers, irrespective of funding source, to be accredited against a recognised standard from 29 November 2022.

No progress has been made towards implementing jurisdictional arrangements for the NQF

5.43 The NQF is significant as it is the first mandatory quality framework to be applied to the AOD treatment sector nationally.[242] However, state and territory governments have responsibility for regulating providers who do not receive government funding.[243] It is intended that providers not complying with the NQF will be subject to regulatory processes as set by each jurisdiction.[244] Stakeholders in the AOD treatment sector told the inquiry that despite the impending requirement for NQF compliance by November 2022, they were not aware of any progress towards implementing the 'jurisdictional arrangements'—either in WA, or in other jurisdictions—that will enforce the NQF requirements for service providers not receiving government funding.[245]

Finding 23

Despite the requirement for Western Australia to develop a regulatory process to ensure that AOD treatment services that do not receive government funding comply with the National Quality Framework for Drug and Alcohol Treatment Services, this has not yet been progressed.

Failure to fully implement the NQF allows private AOD treatment providers to continue self-regulating

5.44 Until WA creates a regulatory process to enforce the NQF, it will be continuing to rely on private AOD treatment providers to self-regulate.

5.45 A number of private service providers have engaged with WANADA regarding accreditation, both in response to the requirement to comply with the NQF and also in recognition of the benefits that accreditation can provide. The CEO of WANADA told the Committee that:

241 Submission 58, WANADA & WAAMH, p. 6; Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 7.

242 Simone Henriksen, 'The National Quality Framework: The Benchmark for the Alcohol and Other Drug Sector in Australia', *Medical Law Review*, vol. 30, no. 1, 2022, p. 122.

243 Department of Health and Aged Care, Ministerial Drug and Alcohol Forum Communique, 14 June 2018, p. 1.

244 Department of Health, *National Quality Framework for Drug and Alcohol Treatment Services*, Commonwealth of Australia, Canberra, 2018, p. 6.

245 Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 5; Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 13.

> Some services, as I said, have been very proactive in regard to wanting to ensure they are delivering quality services. And it is not just [the NQF] that is driving that; it is a willingness and a desire to be operating in a safe and quality way.[246]

5.46 The NQF was only emerging toward the end of the Esther Foundation's operations. The Esther Foundation initiated steps toward gaining accreditation that, if obtained, would have made it compliant with the NQF requirements, as discussed in Chapter 4. However, had it chosen to not pursue accreditation, or had not achieved accreditation by November 2022, there would not have been any consequences.

5.47 It is encouraging that private AOD treatment providers are seeking accreditation. However, a regulatory gap remains where there is no mechanism to compel private providers to become accredited, or to prevent them from operating if they fail to obtain accreditation. Witnesses noted that this potentially exposes consumers to a risk of poor quality or inappropriate treatment, and undermines community confidence in the sector.[247] The vulnerability of individuals seeking AOD treatment services requires a more robust regulatory regime.

Finding 24

Failing to regulate AOD providers who do not receive government funding exposes vulnerable consumers to potential harm, and undermines community confidence in the sector.

Facilities receiving government support should be providing safe and quality services

5.48 Senior government figures made public statements praising the work of the Esther Foundation. In doing so, they contributed to the social licence so crucial to the success of organisations fundamentally reliant on trust and goodwill. Although there is no suggestion that they knew anything of later revelations, it is clear that to outside observers such statements lend a stamp of legitimacy to and confidence in these institutions.

5.49 Because the Esther Foundation was not a funded service provider, it was not subject to any contract management arrangements.[248] These arrangements are intended to ensure both parties have clarity regarding the expectations, and to give agencies some oversight of service providers. This is done by including various requirements in the service agreement, such as key performance indicators and outcomes to be achieved, regular reporting and service evaluation.[249] It is also through these agreements that agencies may incorporate service-specific safety and quality standards, such as accreditation against an approved standard.

5.50 However, WA government agencies did provide support to the Foundation in the form of the acquisition of physical premises for the Foundation, leasing, small grants, referrals, and placements of individuals with the service. Many of these were significant financial sums.

246 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 8.
247 Submission 27, Mrs Simone Henriksen, p. 8.
248 Submission 50, Department of Communities, p. 18.
249 Submission 50A, Department of Communities, p. 5.

Full details of this support are included at Appendix 5. In the Committee's view, it is worth considering whether this support should have been contingent upon the Esther Foundation meeting sector-specific safety and quality standards.

5.51 WANADA submitted recommendations to the inquiry in support of ensuring that government support—including service commissioning, grant funding and referrals—meet sector specific quality requirements.[250] However, there are challenges in ensuring government agencies only provide grant funding to services that meet sector-specific quality standards.

5.52 The Department of Communities told us that although sector-specific quality standards may be included in grants that the agency issues, this can be difficult to achieve where grants are used as a mechanism for funding 'discrete projects, innovative trials, pilot programs, research of a non-commercial nature of a capacity building project for a discrete period of time.'[251] We heard that 'enforcing quality requirements may negatively impact growth in the sector by precluding non-government organisations (NGOs) in a capacity building phase' and that 'precluding potential NGOs on this basis will work against sector strengthening initiatives that encourage sustainability and innovation in the market to give service users choice.'[252]

5.53 Evidence to this inquiry was limited with respect to whole-of-government grant funding arrangements. However, concerning our focus on health services—the evidence overwhelmingly pointed to the need for measures to ensure that facilities are meeting sector-specific quality requirements. New regulatory mechanisms are required to improve oversight and prevent services from operating where they are unsafe and pose a risk to the community. These regulations need to be informed by the level of risk associated with the operations of different services.

5.54 Services where there are higher risks because of the vulnerability of individuals and the setting that treatment is provided in—for example residential rehabilitation settings, like the Esther Foundation—necessarily require greater safety and quality controls, including options for licensing, accreditation and oversight by a regulator. This is in contrast to low risk settings, where it may be better suited to rely on effective oversight through complaints mechanisms that can investigate individual concerns. These sorts of options for regulation are discussed further in the following chapters, and would capture organisations that receive government support.

250 Submission 58, WANADA & WAAMH, p. 3.
251 Submission 50A, Department of Communities, p. 6.
252 *ibid.*

Chapter 6

Why and how to regulate private mental health and AOD treatment services

6.1 Robust frameworks that regulate private health facilities and health care workers in Australia include mechanisms which act as a barrier to entry; ensuring healthcare providers fulfil licensing, registration or accreditation requirements to operate. These sorts of mechanisms, which are often referred to as 'positive' regulatory regimes, are discussed in this chapter.

Why should services be regulated?

Self-regulation is not an appropriate regulatory model in healthcare

6.2 As discussed in Chapter 5, gaps in the existing legislative and regulatory frameworks mean that private mental health and AOD treatment service providers are essentially left to self-regulate. Self-regulation is recommended as a regulatory model when there is no strong public interest or public safety issues in the sector. There are other benefits to self-regulation as a regulatory model, such as being low cost, flexible and responsive to industry needs.[253]

6.3 However, self-regulation is often not an appropriate regulatory model in healthcare, particularly for protecting vulnerable consumers:[254]

> Using a self-regulatory model for health care has been widely criticised for an apparent pattern of unacceptable tolerance for unprofessional conduct. Self-regulation can result in the industry being self-serving, having inadequate sanctions and harbouring 'free-rider' problems.[255]

Finding 25

The existing self-regulatory model that applies to private mental health and AOD treatment providers does not adequately protect the vulnerable consumers of these services.

253 Simone Henriksen and Dominique Moritz, 'Regulation: The Panacea for Private Rehabilitation Centres', *Flinders Law Journal*, vol. 20, 2018, p. 272.
254 Submission 34, Australian Lawyers Alliance, p. 6.
255 Simone Henriksen and Dominique Moritz, 'Regulation: The Panacea for Private Rehabilitation Centres', *Flinders Law Journal*, vol. 20, 2018, p. 272.

The absence of regulation has enabled private service providers to respond to unmet need

6.4 Sector stakeholders attributed the emergence of private providers to an ongoing shortage of AOD treatment and mental health services.[256] By some estimates, the AOD treatment sector only has enough funding to meet half the demand.[257] This provides an opportunity for private providers to fill the gap. While there is no suggestion that all private providers are problematic, without regulation those that are problematic can establish and operate completely unchecked.[258]

6.5 In some circumstances, unmet need coupled with unregulated services can lead to people accessing inappropriate treatments. AODCCC told us that given the lack of available beds and resources, where an individual is in crisis there is pressure 'to just get them somewhere', even though the placement may not meet their needs.[259] In a residential service, it is unrealistic to say that people who are unsatisfied or disagree with the way things are done are free to leave at any time. Rather, external pressures, such as justice intervention, and lack of alternatives may leave some residents particularly vulnerable and may effectively force them to remain in inappropriate or unsafe services.[260]

> ***If you have got a range of unregulated services in the mix, somebody could end up in a service that is not appropriately resourced or skilled to provide those supports… That is a very risky scenario and can certainly compound trauma for that individual, lack of empowerment, ability to make choices for themselves.***
>
> *- Mr Alex Arpino, AODCCC*

6.6 Ultimately, diversity in the mental health and AOD treatment sectors is a strength and can enable consumers to access their preferred services. However, this diversity must be fundamentally underpinned by a consistent and balanced approach to quality and accountability.[261] All people seeking treatment and support from services deserve and are entitled to safety, respect, and high quality, trustworthy services, regardless of the service funding arrangements.[262] Faith-based services must be regulated to the same standards as any other organisation and must restrict their funded work to the terms of their contract.[263]

> …a lot of these [service providers] are certainly going in with the best intentions to want to support people, and not all of these experiences are negative for individuals. One of the main points we wanted to emphasise is [a] diversity of options [is] very, very important; that there may be those that align with a religious

256 Submission 58, WANADA and WAAMH, p. 2; Submission 33, 360 Edge, p. 1; Submission 34, Australian Lawyers Alliance, p. 6.
257 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 2; Submission 33, 360 Edge, p. 1.
258 Professor Nicole Lee, 360edge, *Transcript of Evidence*, 3 August 2022, p. 2; Ms Jill Rundle, WANADA, *Transcript of Evidence*, 17 August 2022, p. 1.
259 Mr Alex Arpino, AODCCC, *Transcript of Evidence*, 3 August 2022, pp. 2-3.
260 Submission 37, AODCCC, p. 1.
261 Submission 58, WANADA and WAAMH, p. 2.
262 Submission 52, Centre for Women's Safety and Wellbeing, p. 3.
263 Submission 62, The Royal Australasian College of Physicians, p. 4.

perspective in their treatment and that those options should be made available. They need to have that clarity and accountability that the accreditation provides to ensure there is that transparency, that we know what is being offered and what safeguards are in place for the consumer.[264]

Finding 26

Unmet demand in mental health and AOD treatment services has created a gap which is being filled by private service providers.

Finding 27

Private service providers can enhance diversity in the mental health and AOD treatment sectors. However, there is a need to ensure they provide quality services that meet the needs of vulnerable consumers.

6.7 Unmet demand has created a significant 'for-profit' market in AOD treatment services in other Australian jurisdictions, and overseas.[265] Media reporting has highlighted some extreme examples of financial exploitation, poor quality service provision and predatory behaviour by 'for profit' service providers.[266]

6.8 A Victorian magistrate has noted that, as an alternative to jail, residential rehabilitation is 'the easiest way to get bail', 'or at least the hardest to refuse'. This creates difficulties when judicial officers are asked to grant defendants bail to private residential rehabilitation facilities when little is known about the quality of service provided.[267] In 2016, Victorian Supreme Court Justice Paul Coghlan described 'for profit' rehabilitation clinics as a 'parasitical' industry that had 'developed on the edge of drug addiction.'[268]

6.9 In the report of its recent review of private AOD treatment services, the Victorian Health Complaints Commissioner noted that 'the intersection between undersupply, vulnerability and the for-profit model is the space where poor consumer outcomes seem most likely to occur.'[269] Some of the common issues investigated as part of that review were similar to

264 Mr Alex Arpino, AODCCC, *Transcript of Evidence*, 3 August 2022, pp. 3-4.

265 Kate McGillivray, 'People should be 'leery' of Ontario's boom in unregulated private drug rehab facilities: expert', *CBC* (web-based), 17 October 2016, accessed 5 October 2022; , <https://www.cbc.ca/>; Brian Mann, 'As Addiction Deaths Surge, Profit-Driven Rehab Industry Faces 'Severe Ethical Crisis', *NPR* (web-based), 15 February 2021, accessed 5 October 2022, <https://www.npr.org/>.

266 'Drug rehabilitation: Regulate private treatment centres' (editorial), *The Age* (web-based), 9 March 2016, accessed 16 May 2022, <https://www.theage.com.au/>; Four Corners, 'Rehab Inc.', *ABC*, 12 September 2016, accessed 5 October 2022, <https://www.abc.net.au/4corners/>; Ben Knight, 'Drug lab allegedly found at former Melbourne brothel the Daily Planet', *ABC News* (web-based), 10 December 2019, accessed 5 October 2022, <https://www.abc.net.au/news/>.

267 Ben Knight, 'Few changes, many concerns as Daily Planet brothel gets green light to reopen as rehab clinic', *ABC News* (web-based), 8 November 2018, accessed 5 October 2022, <https://www.abc.net.au/news/>.

268 Padraic Murphy, 'Judge slams clinics', *Herald Sun* (web-based), 8 September 2016, accessed 5 October 2022, <https://www.heraldsun.com.au>.

269 Health Complaints Commissioner (Victoria), *Review of private health service providers offering alcohol and other drug rehabilitation and counselling services in Victoria*, Melbourne, 2021, p. 9.

complaints raised regarding the Esther Foundation, including unqualified staff, poor handling of adverse events, poor complaint handling and children being treated in adult facilities.[270]

6.10 The Committee did not receive evidence regarding 'for-profit' service providers in WA. However, it is easy to see how these providers might emerge in WA if unmet demand is not addressed and a more robust regulatory framework is not established.

Finding 28

Failing to address unmet demand and lack of regulation in the mental health and AOD treatment sectors is likely to encourage growth of 'for profit' service providers in Western Australia. These services may pose a greater risk to consumers.

Consumers can't access information to assess the quality and safety of unregulated service providers

6.11 Under a self-regulatory system, it can be difficult for consumers to determine the quality of services, whether any complaints have been made about the service or make any critical evaluation of the service before commencing treatment.[271] The only available tools may be limited to the service's website and marketing materials. Stakeholders identified that this lack of information limits consumers' ability to make an informed choice.[272]

6.12 Regulation will provide independent assurance to consumers about the quality and safety of private services.

> ***Unfortunately, we do not have enough community literacy around quality or what to expect from accessing services. It is not there and so they are not aware of what questions they need to ask when they go to a service to ensure that they are going to be receiving safe, quality, evidence-informed practice.***
>
> *- Ms Jill Rundle, WANADA*

Finding 29

Regulation supports transparency, which enables consumers to access reliable information to make informed decisions about their treatment.

The prevalence of unregulated facilities is unknown

6.13 Beyond allegations made about the Esther Foundation, the Committee heard concerns or complaints about a small number of other unregulated facilities operating in WA which promote themselves as providing mental health and AOD treatment services, or support for a broad range of 'life-controlling issues'.

6.14 Lack of regulation means there is little visibility of such facilities. Stakeholders told us they only have anecdotal feedback on these services;[273] they 'fly under the radar' and do not

270 Health Complaints Commissioner (Victoria), *Review of private health service providers offering alcohol and other drug rehabilitation and counselling services in Victoria*, Melbourne, 2021, p. 47.
271 Simone Henriksen and Dominique Moritz, 'Regulation: The Panacea for Private Rehabilitation Centres', *Flinders Law Journal*, vol. 20, 2018, p. 275.
272 Submission 37, AODCCC, p. 2.
273 Ms Taryn Harvey, WAAMH, *Transcript of Evidence*, 19 August 2022, p. 6.

interact with the rest of the sector.[274] This makes it impossible to determine exactly how prevalent unregulated facilities are, what sorts of services they are providing or what their outcomes are.[275] WANADA said that regulation would provide a much better picture of services available in the system to identify gaps and inform government planning approaches.[276]

6.15 The Department of Health identified that over the past 15 years, LARU has made inquiries of about 40 facilities following advice from stakeholders that facilities may be operating in a way that would require them to be licensed under the PHHS Act:

> …out of 40 or so facilities, one or two have gone on to be licensed but by far the majority have responded to us and even provided a statutory declaration stating that they did not meet the definition, and that is where our inquiries have ended.[277]

6.16 The CEO of WAAMH advised that:

> I suspect that there are other people out there who could potentially meet the definition of a [private] psychiatric hostel because of the people they are housing, but they do not tout themselves as a mental health service; they just happen to be a place where several people with mental health issues will be living.[278]

6.17 The Department of Justice said it is likely that there are further victims of abuse at other unregulated health services. In particular, the Office of the Commissioner for Victims of Crime has concerns about services such as residential and non-residential conversion therapy centres and treatment facilities which rely on religious conversion as a therapeutic practice.[279]

6.18 The Mental Health Commission told us that determining the prevalence of unregulated private facilities is beyond their scope. However, it would be worthy of investigation because there is concern in the community that facilities are blurring the lines or re-labelling the services they promote themselves as providing.[280] The risks associated with this were a consistent theme throughout the inquiry. At the very least, it causes misunderstanding and a gap between consumer expectations and actual service provision.[281] At worst, it allows unscrupulous providers to evade regulation.[282]

6.19 The ways that a regulatory system can minimise these risks are discussed further below.

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274 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 8.
275 Submission 33, 360edge, p. 1.
276 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 4.
277 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 5.
278 Ms Taryn Harvey, WAAMH, *Transcript of Evidence*, 17 August 2022, p. 5.
279 Submission 48, Department of Justice, p. 4.
280 Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 4.
281 *ibid.*.
282 Submission 58, WANADA and WAAMH, p. 3; Mr Lindsay Hale and Mr Iain Hill, Director, Treatment Services, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 8; Mr Alex Arpino, AODCCC, *Transcript of Evidence*, 3 August 2022, p. 4; Ms Sarah Cowie, Director and Chief Executive Officer, Health and Disability Service Complaints Office, *Transcript of Evidence,* 3 August 2022, p. 5.

Finding 30

There is little visibility over the prevalence or nature of unregulated private health facilities.

How should services be regulated?

The PHHS Act needs review and reform

6.20 We consider that conducting a full review of the PHHS Act would be the starting point to reforming the regulation of private healthcare facilities, accommodation-based mental health services and AOD treatment services. The implementation of subsequent recommendations in this chapter will depend on the outcomes of this review.

6.21 The Department of Health told the Committee that there is a need for review of the PHHS Act and associated regulations 'that are outdated, silent on multiple issues facing the rapidly evolving private health industry and do not support contemporary regulation.'[283] When the Committee asked the Department of Health about the limitations of the PHHS Act, including its lack of powers of inspection, the Committee heard:

> …that is the problem with it being a 1927 act. There have been changes to the act since 1927; it has evolved, obviously. It did get separated into public and private and there have been changes to it, but it has not been comprehensively reviewed.[284]

6.22 The PHHS Act stipulates that the Act was to be reviewed in 1991 and every five years after that. However, the Department of Health advised that there has been no review.[285]

> We have obviously been aware of the need to review the act for quite some time, and it actually was intended that it would be reviewed back in 2016 when the original act was split into the public and private components. So some work was undertaken then but just was not able to be completed for resourcing requirements.[286]

Finding 31

There has been no statutory review of the *Private Hospitals and Health Facilities Act 1927.*

6.23 A review of the PHHS Act could consider changes to rectify the limitations discussed in Chapter 5 regarding definitions and powers of inspection. Additionally, it could consider how the legislative and regulatory provisions could be restructured to be more responsive to

283 Submission 65, Department of Health, p. 2.

284 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 7. For the sake of clarity, a statutory review was conducted of the predecessor Act to the PHHS Act, the *Hospitals and Health Services Act 1927*, prior to the introduction of the *Health Services Bill 2016.* However, the components of that Act that related to regulation of private facilities were not comprehensively reviewed.

285 Dr Christina Bertilone, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 2.

286 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 2.

emerging issues, and whether there is a need to expand or amend the range of facilities that require regulation.

6.24 The Department of Health has already undertaken some work in this regard, and its proactive approach is commendable. It has consulted with consumers, carers, advocates and licence holders through committees and surveys to identify where the existing regulatory scheme is not meeting contemporary requirements. It has also sought legal advice on how to overcome the regulatory gaps and challenges it has identified, not only in relation to facilities such as the Esther Foundation but also regarding the intersection with specialist disability accommodation under the National Disability Insurance Scheme.[287]

6.25 This has led the Department to consider two main options for reform: review and amend the PHHS Act, or remove private psychiatric hostels from the PHHS Act entirely and create a separate statutory regime for accommodation-based mental health services.[288]

6.26 These options are more comprehensively addressed in the legal advice provided to the Department of Health, which suggests that the second option outlined above has been done in some other Australian jurisdictions and would be the most appropriate. The Committee takes no view on the matter except to say that the most appropriate option will ultimately be best determined in the context of a full review of the PHHS Act. Any changes to the PHHS Act should allow for risk-based regulation with a focus on outcomes, clearly articulate legislative requirements, avoid duplication and allow for effective administration and enforcement of the legislation.[289] As mentioned above, a regulatory system also supports transparency so that consumers can make comparisons between facilities and the services they provide.

Shifting key content into the regulations allows for flexibility and agility

6.27 With either option for reforming the PHHS Act, it would be beneficial for the categories or classes of services requiring licensing to be prescribed and amended within the associated regulations rather than the Act.[290] This approach has been implemented in New South Wales and Victoria, and has been shown to be sufficiently flexible and agile to respond effectively to services which emerge or change rapidly and require licensing.[291] For example, in March 2017, it became a requirement for any facility in New South Wales undertaking certain cosmetic surgery procedures to be licensed in accordance with the *Private Health Facilities Act 2007*. These requirements were introduced following serious incidents involving cosmetic surgery in unlicensed facilities.[292] Including cosmetic surgery in the licensing regime was able to be done by adding it to the list of prescribed services or treatments contained in

287 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 2.
288 *ibid*.
289 Submission 65, Department of Health, p. 2.
290 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, pp. 2-3; Submission 58, WANADA & WAAMH, p. 3.
291 *Private Health Facilities Regulation 2017* (NSW); *Health Services (Health Service Establishments) Regulations 2013* (Vic).
292 NSW Health, *Cosmetic surgery legislation*, 9 February 2022, accessed 21 September 2022, <https://www.health.nsw.gov.au/Hospitals/privatehealth/Pages/cosmetic-surgery-class.aspx>.

the regulations, which are defined as 'private health facilities' in the Act. No amendment to the Act was required.

6.28 The Department of Health also described the benefits of an approach where the applicable standards are attached to the prescribed services or treatments provided by a facility, rather than the facility itself:

> So you are then flexible. You are not over-regulating where you have a facility that has got a specific limited service provision, but you are not under-regulating where you have an extensive health facility that is perhaps very complex or has a challenging cohort. So that agility that you refer to, we think that that is a really good way to approach regulation going forward.[293]

6.29 We discuss later in this chapter whether AOD treatment services should be incorporated into the PHHS Act as a prescribed service, or regulated under a separate scheme.

Finding 32

Prescribing the categories of services required to be licensed in the regulations of the *Private Health Services Act 1927* will allow for more responsive regulation of emerging health services.

Finding 33

There are benefits to prescribing licensing categories by service definition rather than facility definition.

Recommendation 1

That the Minister for Health and Mental Health direct that a statutory review of the *Private Hospitals and Health Services Act 1927* be conducted, with particular consideration given to:

- updating and clarifying specific service definitions
- expanding the regulator's investigatory and enforcement powers
- allowing for services that require licensing to be prescribed within the regulations rather than the Act
- whether accommodation-based mental health services should be put into a separate legislative and regulatory regime
- whether AOD treatment services should be included as a prescribed service
- enabling transparency so that consumers can make informed choices when selecting a service.

293 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 3.

Implementation of the NQF requires a regulatory process to be established for private AOD treatment services

6.30 Having endorsed the NQF, WA is obliged to implement it to full effect. This requires the establishment of a regulatory process that will cover AOD treatment providers that do not receive government funding. Given that no other jurisdiction has apparently made progress towards this, there is an opportunity for Western Australia to be a leader in this regard:

> I know each jurisdiction has struggled or probably went, "Not until 2022." Lo and behold, it is becoming an issue, now, for government agencies and state and territory governments to look at how they might do this… Let us be the first![294]

6.31 As each jurisdiction progresses towards implementing the NQF, it is also important to minimise differences in monitoring and enforcing compliance. Significant differences may encourage some providers to jurisdiction shop to avoid compliance.[295] National consistency will optimise safety and integrate services to provide streamlined care.[296]

Finding 34

Full implementation of the National Quality Framework for Drug and Alcohol Treatment Services requires the establishment of a regulatory process for AOD treatment providers that do not receive government funding.

Recommendation 2

That the Minister for Health and Mental Health ensures that a regulatory process for AOD treatment services is established, to give full effect to the National Quality Framework for Drug and Alcohol Treatment Services. This should involve consideration of a licensing scheme for AOD treatment providers.

There would be benefits in going beyond the requirements of the NQF

6.32 Some evidence to the inquiry supported establishing a licensing scheme that would go beyond simply implementing the requirements of the NQF. NQF compliance simply requires AOD treatment providers to obtain and maintain accreditation against an approved standard. Accreditation only indicates whether minimum standards are met or unmet, and some of the NQF standards are not AOD sector-specific.

6.33 By way of comparison, accreditation is just one of several requirements that the Mental Health Commission applies to all mental health and AOD providers that it funds. The MHC also requires:

- Compliance with relevant legislation and policies
- Bi-annual reporting requirements

294 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 13.
295 Simone Henriksen, 'The National Quality Framework: The Benchmark for the Alcohol and Other Drug Sector in Australia', *Medical Law Review*, vol. 30, no. 1, 2022, p. 134.
296 Submission 35, Australian Psychological Society, p. 2.

- Financial reporting
- Contract management
- Service reviews, and
- Notifiable Incident reporting.[297]

6.34 Arguably, the same requirements should apply to all services regardless of their funding status.

6.35 The Mental Health Commission went further to suggest that NQF compliance for AOD treatment services that receive government funding should also be included in any legislative implementation. Although the MHC ensures, through its contractual arrangements, that any commissioned AOD treatment services meet the NQF requirements, 'it would be better if that was strengthened with legislative support.'[298]

6.36 The Mental Health Commission's approach in this regard is consistent with other evidence that noted:

- contractual arrangements are not an appropriately responsive regulatory mechanism—failure to maintain accreditation would likely result in termination of the contractual agreement, which is punitive and a 'blunt instrument' for encouraging compliance and quality improvement. Appropriately responsive regulation would incorporate a range of compliance strategies and sanctions.[299]
- monitoring and enforcement mechanisms for the NQF should not distinguish between service providers on the basis of funding—differentiation of providers based on funding has the potential to negatively impact the legitimacy of the NQF. For example, there may be a perception of procedural injustice if providers with different funding statuses receive different sanctions for the same or similar breach of a standard.[300]

6.37 Some evidence to the inquiry also suggested that regulatory reform in relation to private AOD treatment providers also presented an opportunity to pursue sector-wide reforms, such as mandating a system for evaluating and publicly reporting on treatment outcomes.[301]

Finding 35

The National Quality Framework for Drug and Alcohol Treatment Services requires accreditation to demonstrate that minimum standards have been met. In developing a regulatory scheme for AOD treatment services, there is an opportunity to go beyond these minimum requirements.

A licensing scheme could do more than just implement the NQF

6.38 Evidence to the inquiry suggested there are two main ways the NQF regulatory process could be implemented:

297 Submission 66, Mental Health Commission, p. 2.
298 Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 4.
299 Submission 27, Simone Henriksen, p. 9.
300 Simone Henriksen, 'The National Quality Framework: The Benchmark for the Alcohol and Other Drug Sector in Australia', *Medical Law Review*, vol. 30, no. 1, 2022, p. 134.
301 Professor Nicole Lee, 360edge, *Transcript of Evidence*, 3 August 2022, pp. 4-5.

- as a standalone scheme, through legislative adoption of the NQF and the establishment and empowerment of a regulatory body to monitor compliance,[302] or
- by incorporating the NQF requirements as part of a licensing scheme for AOD treatment providers.

6.39 Stakeholders expressed broad support for introducing a licensing scheme for private AOD treatment providers. This was a key recommendation of the Victorian Health Complaints Commissioner's recent review of private health service providers offering alcohol and other drug rehabilitation and counselling services, although the recommendation has not been implemented.[303]

6.40 A licensing scheme could regulate in a way that is complementary to the objectives of the NQF—not only by requiring NQF compliance as a condition of the licence but imposing other conditions as determined to be appropriate by the regulatory body, in consultation with the sector.

AOD licensing could sit within a revised PHHS Act, or in a separate scheme

6.41 Although evidence to the inquiry was broadly in support of a licensing scheme for private AOD treatment services, the evidence was not clear on where this would best sit—within a revised PHHS Act and under the responsibility of LARU, or in a standalone act governed by a different regulatory body. The Department of Health told us that 'there is more work to be done' to establish where the regulation of AOD treatment services would best sit.[304] The Mental Health Commission told us it had not formed an official view on this issue, although there is 'clear capability' within LARU.[305] WANADA said that LARU would be an appropriate regulatory body if its capacity was expanded to be 'fit for purpose'. Otherwise, a separate regulatory body would also be an option.[306]

6.42 In other Australian jurisdictions, private AOD treatment services are not covered by regulatory regimes for private hospitals and health services.[307] New South Wales and Victoria incorporate limited AOD treatment services in their equivalent legislation for private health facilities and services, but only to the extent that rapid opioid detoxification, acute AOD detoxification or 'specialist rehabilitation' services (administered by a medical practitioner) are provided.[308] These inclusions seem to align with a strongly clinical focus of the other prescribed services included in those regulatory regimes.

6.43 If regulation of AOD treatment services was to be included in a standalone act, both the Department of Health and the Mental Health Commission advised that the three 'pillars'

302 Submission 66, Mental Health Commission, p. 2.
303 Professor Nicole Lee, 360edge, *Transcript of Evidence*, 3 August 2022, p. 4.
304 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 3.
305 Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 5.
306 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 13.
307 MinterEllison, Letter to Mrs Vanessa MacDonald, 13 May 2022, p. 7.
308 *Private Health Facilities Regulation 2017* (NSW), r. 4; *Health Services (Health Service Establishments) Regulations 2013* (Vic), r. 7.

which support safe patient care under the PHHS Act (as outlined in Chapter 5) would also be suitable and effective in relation to AOD treatment services.[309]

Any regulatory scheme should be risk-based and fully incorporate sector-specific quality requirements

6.44 As recommended above, a review of the PHHS Act should consider whether regulation of accommodation-based mental health services and AOD treatment services would best sit within the PHHS Act or in a separate scheme. Depending on the outcomes of the review, a separate scheme could incorporate AOD treatment services, accommodation-based mental health services, or both.

6.45 In relation to these options, WANADA expressed concern that the PHHS Act is limited 'in terms of recognising the sector-specific requirements for quality.'[310] WAAMH was concerned that in relation to accommodation-based mental health services, current mechanisms 'are not adequately capturing the need for recovery-oriented, human rights-driven care and support services.'[311] These concerns will need to be addressed in determining where the regulation of these services best sits.

6.46 Other factors that will need to be considered in the design and implementation of a scheme are outlined below.

Scope of services to be licensed

6.47 As noted above, a key concern during the inquiry has been the ability of organisations to evade regulation by re-labelling the nature of their facility or the services they provide.[312] A licensing scheme will require significant consultation across affected sectors to:

- clearly identify which services are intended to be captured by the scheme
- develop sector-specific service definitions and quality requirements.

6.48 This clarity is particularly important in light of the overlap of mental health, AOD, housing and community services, and an increasing trend towards holistic services in recognition of the benefits they offer to consumers experiencing co-occurring issues.

6.49 For the AOD sector, WANADA told us 'any service that is delivering treatment, whether they call it treatment themselves, needs to be captured', which is in line with the requirements of the NQF.[313]

309 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 3; Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 5.
310 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 10.
311 Ms Taryn Harvey, WAAMH, *Transcript of Evidence*, 19 August 2022, p. 10.
312 Submission 58, WANADA & WAAMH, p. 3; Mr Alex Arpino, AODCCC, *Transcript of Evidence*, 3 August 2022, p. 4.
313 Ms Jill Rundle, WANADA, *Transcript of Evidence*, 19 August 2022, p. 10.

6.50 Throughout the inquiry, the particular vulnerability of people in residential services has been highlighted as demanding more robust regulation.[314] This is in line with the risk-based approach recommended by WAAMH in relation to regulating mental health services:

> I do not think we want to create an environment where everything becomes regulated. There are areas where there are higher levels of risk because of the potential dependence and vulnerability of the people and their potential reliance on the intervention that is being supported.[315]

6.51 If accommodation-based mental health services are removed from the PHHS Act following review, we would expect that these would be appropriately captured in this scheme as a higher risk service. It may not be appropriate to capture lower risk mental health services, or lower regulatory requirements may be applied. As will be discussed in Chapter 7, low risk unregulated services may also be 'negatively' regulated by the Health and Disability Services Complaints Office (HaDSCO).

6.52 Given that licensing is a barrier to service entry, there will also need to be careful consideration of the impacts of imposing a significant regulatory burden on service providers[316] and preserving a diversity of options in services, service models and providers.[317]

Powers and capabilities of regulatory body

6.53 In light of the difficulties described above with organisations re-labelling their services and facilities, any regulatory body for AOD and mental health services should be empowered to look to the function of the services that an organisation may be providing, rather than how they may brand themselves.[318] This will avoid the limitations currently experienced by LARU, described above, where they are unable to investigate and enforce the requirements of the PHHS Act.

As is also noted above, appropriately responsive regulation would incorporate a range of compliance strategies and sanctions ranging from cooperative to punitive.[319]

314 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 4; Mr Lindsay Hale, Mental Health Commission, *Transcript of Evidence*, 10 August 2022, p. 4.
315 Ms Taryn Harvey, WAAMH, *Transcript of Evidence*, 19 August 2022, p. 9.
316 Mr Colin Penter, WAAMH, *Transcript of Evidence*, 19 August 2022, p. 11.
317 Mr Alex Arpino, AODCCC, *Transcript of Evidence*, 3 August 2022, p. 3.
318 Mr Ethan James, Manager, Advocacy and Systems, WANADA, *Transcript of Evidence*, 19 August 2022, p. 6.
319 Simone Henriksen and Dominique Moritz, 'Regulation: The Panacea for Private Rehabilitation Centres', *Flinders Law Journal*, vol. 20, 2018, pp. 290-291.

Recommendation 3

That the Minister for Health and Mental Health establish a licensing and regulatory scheme for private mental health and AOD treatment services, with particular consideration given to:

- developing sector-specific service definitions in consultation with the sector
- incorporating the requirements of the National Quality Framework for Drug and Alcohol Treatment Services
- incorporating sector-specific quality requirements
- using a risk-based approach to determine the level of regulatory input required for different services
- giving the regulator investigatory and enforcement powers in relation to non-compliant services.

Chapter 7

Health Complaints Entities

7.1 In Chapter 6, we discussed 'positive' regulatory regimes which include mechanisms that are a barrier to entry. Regulatory frameworks also include avenues for when things go wrong—Health Complaints Entities (HCEs) exist in Australian states and territories to investigate and take action in response to complaints made against health service providers. Although these HCEs are not necessarily regulators, their capacity as complaint handlers places them in a safety and quality framework that exists across Australia.[320]

7.2 Health complaints mechanisms can be understood as 'negative' regulatory regimes, which focus on dealing with non-compliance of established standards. These regimes, and how they work to complement 'positive' regulatory regimes as part of a broader framework to maintain public health and safety, are discussed in this chapter.

Excluding unregistered health service providers where they pose a risk to the public

7.3 Across Australia, mechanisms exist to deal with complaints made about registered health practitioners. However, the regulation of unregistered or deregistered health practitioners is still being established.

7.4 A nationwide regulation scheme that excludes the dangerous provision of health services by unregistered practitioners has gained momentum over the past decade.[321] Through the implementation of the National Code of Conduct for Health Care Workers (National Code), WA will join other Australian jurisdictions that already have provisions in place to support HCEs investigating and taking action against unregistered health practitioners that present a risk to the public.

Positive and negative regulatory regimes should be complementary

7.5 The implementation of the National Code will address a regulatory gap that exists in relation to unregistered individual health care workers providing services, such as counsellors. However, a gap will remain with respect to organisations that are not captured by positive regulatory schemes.

7.6 As discussed in the previous chapter, proposed changes to the PHHS Act, and creation of a regulatory and licensing scheme for mental health and AOD treatment services, would broaden the range of health services captured by a regulatory body. Although consultation needs to occur to determine exactly which services should be captured by licensing, it is likely these services will include those where there is a higher level of risk involved for the individual accessing the service—for instance, a residential rehabilitation facility.

320 Ms Sarah Cowie, Health and Disability Services Complaints Office, *Transcript of Evidence*, 3 August, p. 8.
321 Ian Freckleton QC, 'Prohibition orders and the regulation of unregistered health practitioners', *Journal of Law and Medicine*, April 2020, p. 551.

7.7 With these changes there will still be organisations that provide health services, which will not be captured. For health services that pose a low risk to the individual, the regulatory requirements of a licensing regime may be unsuitable. Licensing requirements in the PHHS Act will not yet exist where new types of health services are still emerging.

> ***In an unregulated space, you do not know that they exist until suddenly you receive a complaint, and these new professions emerge from time to time that deliver these services.***
>
> *- Ms Sarah Cowie, HaDSCO*

7.8 In these contexts, complaints can be the only way to have visibility of a service provider—there needs to be a body that can receive and investigate those complaints, to complement the provisions provided by positive regulatory schemes.

7.9 The Committee heard about progress in other Australian jurisdictions to ensure that provisions similar to those set out in the National Code exist to allow HCEs to investigate and take action against organisations as well as individuals in response to complaints or concerns about the safety of their practices. As is discussed below, pursuing similar reforms could be an option for WA to overcome certain gaps in the regulation of private health facilities that are not captured by the PHHS Act or other licensing schemes.

The Health and Disability Services Complaints Office

7.10 In WA, the Health and Disability Services Complaints Office (HaDSCO) is tasked with providing an impartial resolution service for complaints relating to health, disability and mental health services in WA, covering the public, private and not-for-profit sectors and prison health services.[322] HaDSCO has two key service areas:

Table 7.1: HaDSCO's key service areas

Service One	Assessment, negotiated settlement, conciliation and investigation of complaints.
Service Two	Education and training in the prevention and resolution of complaints.

7.11 Complaints received can be handled using an alternative dispute resolution (ADR) approach, or through investigation. There is currently a greater focus on ADR, which requires the complainant and service provider to agree to participate in a negotiated settlement process that is facilitated by HaDSCO.[323] HaDSCO only investigates a small number of cases.[324]

Limitations of HaDSCO's powers and jurisdiction

7.12 Currently, the powers and jurisdiction afforded to HaDSCO restrict its capacity to handle complaints or concerns about unregulated health service providers.

HaDSCO does not have determinative powers

7.13 Following an investigation, HaDSCO's powers only enable it to make a recommendation to the service provider subject to investigation. HaDSCO has no ability to compel a service

322 Submission 45, Health and Disability Services Complaints Office, p. 2.
323 *ibid.*, p. 5.
324 *ibid.*, p. 6.

provider to take remedial action, or to prevent an individual or an organisation from continuing to provide health services.[325]

HaDSCO cannot undertake own motion investigations

7.14 HaDSCO's jurisdiction only allows it to accept a complaint made by an individual who received the health, disability or mental health service that is the subject of complaint, or from their representative or carer. The Minister for Health can also refer matters to HaDSCO for investigation. However no provisions exist to enable conducting own motion investigations.[326]

The definition of 'health service' does not necessarily extend to unregulated facilities

7.15 HaDSCO can only accept complaints against services defined as a 'health service' in the *Health and Disability Services (Complaints) Act 1995* (HaDSC Act). This includes, among other things, any service provided in the diagnosis or treatment of a physical or mental disorder or suspected disorder. Similar definitions are contained within the *Mental Health Act 2014* (Mental Health Act) and the *Disability Services Act 1993 (*Disability Services Act).[327]

7.16 Complaints concerning both organisations or individual practitioners can be accepted by HaDSCO, if the services they provide are consistent with the definition of a 'health service', a 'mental health service' or a 'disability service'. In circumstances where it is not clear if the type of service provided meets the definition, HaDSCO may obtain legal advice.[328]

7.17 Services provided by private unregulated health facilities may not meet the definition of a 'health service' under the HaDSC Act. However, if the services within such facilities are provided by either registered or unregistered health practitioners, these services may meet the definition. HaDSCO considers such instances on a case-by-case basis.[329]

7.18 Where a facility is not captured by the definition of a 'health service' under the HaDSC Act, the oversight role of HaDSCO would only extend to the individual practitioner and not the organisation as a whole, which HaDSCO identifies as a regulatory gap.[330]

Finding 36

Private unregulated health facilities may not meet the definition of a 'health service' under the *Health and Disability Services (Complaints) Act 1995.*

Finding 37

In instances where a facility does not meet the definition of a 'health service' under the *Health and Disability Services (Complaints) Act 1995*, the oversight role of the Health and Disability Services Complaints Office may extend to individual health practitioners, rather than the organisation as a whole.

325 Submission 45, Health and Disability Services Complaints Office, p. 6.
326 *ibid.*, p. 5.
327 *ibid.*, p. 4.
328 *ibid.*, p. 4.
329 *ibid.*, p. 4.
330 *ibid.*, p. 5.

Finding 38

The Health and Disability Services Complaints Office does not have a clear role as an external review agency for complaints about organisations that are not captured by the definition of a 'health service' in the *Health and Disability Services (Complaints) Act 1995*.

Unregulated organisations may struggle to comply with complaint handling standards

7.19 The HaDSC Act, Mental Health Act and Disability Services Act provide the regulatory framework for complaint management in relation to health, disability and mental health services in WA. The principles in the *Guidelines for complaint management organizations* (the Complaints Standard) provide guidance on complaint management and form part of the regulatory framework.[331]

7.20 One of the guiding principles of the Complaints Standard is that the person making the complaint is informed of the availability of external review mechanisms. In WA, these external review mechanisms are provided by HaDSCO for complaints about health, mental health and disability services.[332]

7.21 As private unregulated facilities may not be captured by the definition of a 'health service' in the HaDSC Act, it's not clear that HaDSCO has a role in providing external review mechanisms for complaints about such facilities. HaDSCO described how:

> At the minimum, there is a lack of clarity about oversight and regulation for an external complaints mechanism for organisations that do not meet the definition of a 'health service' in the HaDSC Act.[333]

7.22 If organisations do not have oversight or external review of their complaints mechanisms, they may be unable to meet established standards:

> While some organisations that provide services in facilities not covered by the definition of 'Health Service' or 'Hospital' in the PHHS Act might have an internal complaint mechanism in place consistent with the Complaints Standard, if there is no oversight or external review agency, the organisation is unable to meet the principles set out in the Complaints Standard for unresolved complaints.[334]

Finding 39

Organisations that provide services not captured by the definition of 'health service' or 'hospital' in the *Private Hospitals and Health Services Act 1927* may be unable to meet established standards for complaint handling, if there is no oversight or external review agency available to review complaints.

331 Submission 45, Health and Disability Services Complaints Office, pp. 3-4.
332 *ibid.*, p. 4.
333 *ibid.*, p. 5.
334 *ibid.*, p. 5.

Legislation recently before the Parliament will address some regulatory gaps, but not all

7.23 HaDSCO's jurisdiction and powers will change with the implementation of the National Code, which has been progressed through the *Health and Disability Services (Complaints) Amendment Bill 2021* (the Amendment Bill). Although the implementation of the National Code will address a number of existing regulatory gaps, HaDSCO will remain limited in its capacity to deal with unregulated health facilities.

Implementation of the National Code will expand HaDSCO's regulatory role

7.24 The Amendment Bill was introduced into the Legislative Assembly on 25 November 2021 and was assented to on 28 October 2022. At the time of our inquiry, it had not yet come into operation.

7.25 The Amendment Bill will expand the regulatory role of HaDSCO by implementing the National Code, which sets minimum standards of practice for unregistered health care workers. It does not restrict entry into practice by requiring a health care worker to register. However, it will allow disciplinary action to be taken against a health care worker who fails to comply with the standards of practice.[335] Developed as a nationally consistent legislative mode, the National Code, or a comparable code of conduct, is already in place in NSW, QLD, SA and VIC.[336]

7.26 The implementation of the National Code through the Amendment Bill will provide a new remit for HaDSCO:

Changes to the definition of 'health service'

7.27 The definition of a 'health service' within the HaDSC Act will be amended to expand the range of health services that fall within HaDSCO's jurisdiction. This will allow the investigation of complaints about the provision of alternative, allied and community health services by individual unregistered health practitioners.[337]

Increased powers

7.28 The new jurisdiction associated with the National Code will have a strong investigation focus where outcomes may include a determinative decision resulting in the issuing of prohibition orders. Such orders may require health care workers to stop their practice or impose conditions on their practice.[338]

Further scope to accept complaints

7.29 HaDSCO will be able to accept complaints about the conduct of a health worker by anyone irrespective of whether they were the service user or not. While this will address a regulatory gap in terms of who can make a complaint, it will only apply to the National Code

335 Submission 45, Health and Disability Services Complaints Office, p. 7.
336 *ibid.*, p. 8.
337 *ibid.*, p. 8.
338 *ibid.*, p. 8.

jurisdiction and not HaDSCO's broader jurisdiction for health, disability and mental health services.[339]

Self-initiated investigations

7.30 Own motion powers will be granted to HaDSCO in relation to National Code matters. The Director of HaDSCO may initiate an investigation into a health care worker's conduct without having received a complaint, if there is a reasonable belief that their provision of health services is unsafe or unethical. While this will also address a regulatory gap, it will only apply to National Code matters and not HaDSCO's broader jurisdiction.[340]

How would provisions set out in the National Code have applied to the Esther Foundation?

7.31 One of the complaints made about the Esther Foundation through submissions to the inquiry was that unregistered healthcare workers were providing services at the facility that were beyond the scope of their qualifications or experience. At times, this led to services being provided in an unsafe way.

7.32 If the National Code had been in place while the Esther Foundation was operating, HaDSCO would have had the ability to handle complaints or concerns about individual healthcare workers at the facility. HaDSCO told the Committee that with the National Code in place it could have:

- Received a complaint from somebody about a practitioner irrespective of whether the complainant was the service user or not.
- If the person that the complaint was about was an unregistered practitioner, HaDSCO could have issued an interim prohibition order if there was evidence or if the Director was reasonably satisfied that they were breaching National Code clauses.
- HaDSCO could have then completed an investigation, which could involve going in to the facility under a warrant.
- At the end of that process, if HaDSCO believed that the practitioner was operating outside of the National Code clauses, it could have issued a prohibition order.[341]

7.33 The case study below illustrates an example of how HaDSCO's new powers could take effect in relation to a concern that was raised about an individual who provided counselling services at the Esther Foundation.

339 Submission 45, Health and Disability Services Complaints Office, p. 8.
340 *ibid.*
341 Ms Sarah Cowie, Health and Disability Services Complaints Office, *Transcript of Evidence*, 3 August 2022, pp. 9-10.

Box 3: Case study – A complaint made about an unregistered practitioner

The Committee received a submission raising concerns about an individual who provided counselling services at the Esther Foundation. The submission identifies that this individual was practising as a registered psychologist and opted to discontinue their registration as a psychologist following a number of notifications that were made to the Australian Health Practitioner Regulation Agency (Ahpra) about the psychologist's practices.

The submission identifies that the Esther Foundation responded appropriately when this was raised with the organisation in 2019, by requiring all practitioners to present copies of their current registrations and insurances (as discussed in Chapter 4). However, the submission raises ongoing concerns that this individual now provides inappropriate counselling services to the public as an unregistered counsellor.[342]

The Committee is not in a position to make findings in relation to this particular individual. However, the scenario described in this submission is an example of where HaDSCO's new remit could take effect, once the National Code is implemented in WA.

In the scenario where an unregistered health worker, such as a counsellor, is the subject of a complaint or there is a reasonable belief that their provision of health services is unsafe or unethical, HaDSCO will have the ability to conduct an investigation.

After completing an investigation, HaDSCO will have the ability to make orders in relation to an individual, such as a counsellor, restricting or prohibiting them from providing services where their conduct presents a serious risk to public health and safety.

Finding 40

If the National Code had been in place while the Esther Foundation was operating, the Health and Disability Services Complaints Office would have had powers to handle complaints or concerns about individual unregistered healthcare workers.

Regulatory gaps in the provision of unregistered health services by organisations

7.34 The implementation of the National Code addresses a number of existing regulatory gaps by providing HaDSCO with greater jurisdiction for matters relating to individual unregistered health practitioners who may provide services at facilities, such as the Esther Foundation, or other settings not covered by the PHHS Act. However, this jurisdiction does not extend beyond an individual to the organisation itself.

7.35 The changes resulting from the implementation of the National Code target individual healthcare workers. HaDSCO told the Committee that:

> …in the future, and currently, if we get a complaint about Esther Foundation itself, yes, we could look at it but we cannot now and we would not, even with the national code in place, have been able to say, "We can prevent you from practising", as an organisation.[343]

7.36 HaDSCO told the Committee that as the National Code cannot be applied to organisations, alternative mechanisms to regulate non-traditional providers of health services may be required in WA, through amendments to the PHHS Act:

342 Closed evidence.

343 Ms Sarah Cowie, Health and Disability Services Complaints Office, *Transcript of Evidence*, 3 August 2022, p. 9.

> While HaDSCO does not have a role in the administration of the PHHS Act, there may be benefits in giving consideration to expanding the definitions used in this Act to include providers of health services in unregulated organisations, thereby applying licensing and accreditation requirements on facilities like those run by the Esther Foundation. Such a regulatory framework would be complementary to both the National Code and the NRAS [National Registration and Accreditation Scheme], which apply to the conduct of individuals.[344]

7.37 The previous chapter of this report considers the benefits in broadening the scope of facilities that are required to be licensed, and establishes that licensing and accreditation requirements should apply to facilities such as the Esther Foundation. However, these licensing and accreditation requirements will likely not apply to all organisations providing health services—potentially including those that are delivered in low-risk settings or provide emerging health services. Given this, we considered whether it would be beneficial to broaden HaDSCO's jurisdiction in relation to organisations, particularly in the context of what is occurring in other Australian jurisdictions.

Finding 41

The implementation of the National Code addresses a number of existing regulatory gaps by providing the Health and Disability Services Complaints Office with greater powers and jurisdiction to handle complaints and concerns about individual unregistered health practitioners. This jurisdiction will not extend to the organisations where such health services may be provided.

Health complaints in other Australian jurisdictions

7.38 A number of Australian states have recognised the need for HCEs to be equipped with a broad jurisdiction for dealing with complaints and concerns about organisations as well as individuals.

Victoria

Powers to deal with organisations that provide health services

7.39 The Victorian Health Complaints Commissioner (VIC HCC) told the Committee how the VIC HCC's jurisdiction would extend to an organisation such as the Esther Foundation, as well its individual employees.[345]

7.40 This is enabled by the Victorian *Health Complaints Act 2016* (Health Complaints Act), which includes a definition of a 'general health service provider' that captures both individuals and body corporates. The Explanatory Memorandum to the *Health Complaints Bill 2016* describes how:

> the definition of health service does not make a distinction between services provided in the public and private sectors and includes provision by both individual practitioners and the legal entities that employ or engage health service providers

344 Submission 45, Health and Disability Services Complaints Office, p. 10.
345 Submission 61, Health Complaints Commissioner (Victoria), p. 4.

> to provide health services (examples include hospitals and community health centres).[346]

7.41 This enables the VIC HCC to make prohibition orders in relation to a general service provider in their personal capacity or as a body corporate. VIC HCC told the Committee that the capacity to make prohibition orders against a body corporate is essential where it is the business entity that offers, promotes and provides the general health service in question.[347]

7.42 By defining health service providers and introducing broader investigation powers, the Health Complaints Act significantly expanded the remit of the VIC HCC and established it as having a clear regulatory role in Victoria with respect to health services.[348]

Increased visibility over unregulated facilities

7.43 Through its expanded remit, the VIC HCC has increased visibility over unregulated health service providers.

7.44 The second reading speech of the Victorian *Health Complaints Bill 2016* identifies that:

> A key objective of the bill is to ensure that better use is made of health complaints information to enable improvements across the healthcare system and, where necessary, to take action to protect the public.
>
> …The commissioner is uniquely placed to learn from complaints and provide feedback to improve the provision of health services.[349]

7.45 The increased visibility over unregulated health service providers, has supported the VIC HCC in undertaking an investigation specifically into the AOD treatment provider sector.

7.46 In 2017, the Victorian Government provided funding to the VIC HCC to tackle unsafe or poor-quality private AOD treatment providers. When the VIC HCC commenced its investigation in May 2018, 29 complaints had been received since February 2017. From May 2018 until August 2019, another 53 complaints were received.[350]

7.47 Basing its investigation off the complaints that had been received, the VIC HCC identified that the key themes within complaints related to:

- exploitative billing practices
- issues around informed consent
- concerns about safety and effectiveness of treatment and inappropriateness of discharge. [351]

346 *ibid.*
347 Submission 61, Health Complaints Commissioner (Victoria), p. 7.
348 *ibid.*, p. 4.
349 Hon Jill Hennessy MP, Minister for Health (Victoria), Legislative Assembly, *Hansard*, 10 February 2016, p. 99.
350 Submission 61, Health Complaints Commissioner (Victoria), p. 8.
351 *ibid.*, p. 17.

7.48 The VIC HCC described how it was clear from the complaints received that there were issues in privately funded AOD treatment services that did not feature in the publicly funded part of this sector.[352]

7.49 These issues are not limited to complaints or concerns about individual healthcare workers. Rather, these are the sorts of issues that need to be addressed at an organisational level. The VIC HCC told us that:

> HCC investigations into private AOD providers have primarily been against the organisation/body corporate, with a focus on improvement of the overall function of the residential rehabilitation facility, and with targeted investigation into the conduct of individual staff where staff member's identity is known or discovered.[353]

7.50 The Victorian Commissioner has not made prohibition orders against an AOD residential rehabilitation service provider as a body corporate.[354]

> The Commissioner decides on a case by case basis, but a decision not to impose an order on a residential rehabilitation service is generally due to reasons such as the impact on the continuity of care for current clients of that service, or the legal ramifications for current clients whose bail conditions require them to be in residential rehabilitation.[355]

7.51 Through its investigation, the VIC HCC identified quality improvements across a number of facilities. However, it concluded that:

> Although the General Code of Conduct provides for a minimum set of legal standards with which all general health service providers in Victoria must comply, the investigation [into private AOD rehabilitation and counselling services] highlighted that the sector has little oversight and structure, and that targeted and specific regulation and registration is needed.[356]

As discussed in Chapter 6, a key recommendation of the investigation was the establishment of a mandatory licensing scheme for all private AOD treatment providers.

New South Wales

7.52 HaDSCO told the Committee about progress NSW was making in providing greater powers to the NSW Health Care Complaints Commission (NSW HCCC) to deal with complaints or concerns about certain organisations that provide health services.

352 *ibid.*, p. 18.
353 Submission 61, Health Complaints Commissioner (Victoria), p. 4.
354 *ibid.*, p. 7.
355 *ibid.*, p. 8.
356 *ibid.*, p. 8.

Box 4: NSW Health Care Complaints Commission

In 2020 NSW amended the *Public Health Act 2010* and *Health Care Complaints Act 1993* to provide the legislative framework for the regulation of relevant health organisations.

A relevant health organisation is defined in the *Health Care Complaints Act 1993* as a 'body that provides a health service'.

Resulting from the legislative changes made, the NSW HCC has a range of powers related to the regulation of health organisations, including:

- The power to receive, assess and investigate complaints against a relevant health organisation that is alleged to have breached the code.
- The power to issue public warning statements.
- The power to issue prohibition orders against relevant health organisations.
- The power to issue public warnings against treatments or health services provided by relevant health organisations.

In March 2022, the NSW Ministry of Health commenced public consultation on a draft code of conduct to ensure it was appropriate for the relevant health organisations. During the course of our inquiry, the code was included in the updated *Public Health Regulation 2022*, which commenced on 1 September 2022.

The legislative changes have resulted in the application of a code of conduct comparable to the National Code to certain types of organisations providing health services in NSW. This contrasts with the National Code scheme being implemented in WA, which is based on the COAG Health Council Final Report and will only be applicable to individual health care workers.

Source: Submission 45, Health and Disability Services Complaints Commissioner, p. 10; NSW Health, *Code of conduct for unregistered health practitioners and health organisations*, 1 September 2022, accessed 7 November 2022, <https://www.health.nsw.gov.au/>.

7.53 There is recognition that a regulatory gap can exist where the application of the National Code relates only to individual health care providers and not organisations. HaDSCO told us that:

> It has been discussed between the states now that the code for individuals has been in place for a number of years in… [New South Wales, Queensland, South Australia and Victoria]. There has been discussion around that regulatory gap and how it [the National Code] does not apply to service providers or organisations.[357]

7.54 Furthermore, HaDSCO has been keenly watching New South Wales '…to see when these regulations are actually finalised and then to see how this code works in practice when it is applied to organisations.'[358]

South Australia

7.55 The South Australian Health and Community Services Complaints Commissioner (SA HCSCC) told the Committee how the definition of 'health service' within state and territory legislation is pivotal in ensuring HCEs can adequately regulate the variety of services occurring within the community.[359]

357 Mr Kieran Handmer, Project Officer, Health and Disability Services Complaints Office, *Transcript of Evidence*, 3 August 2022, p. 7.

358 *ibid.*

359 Submission 44, Health and Community Services Complaints Commissioner (South Australia), p. 2.

7.56 In SA, the *Health and Community Services Complaints Act 2004* (the HCSC Act) provides a broad definition of 'health service', which means the SA HCSCC can investigate facilities such as the Esther Foundation. The SA HCSCC told the Committee how the HCSC Act allows the Commissioner to investigate health services in circumstances where South Australia's Code of Conduct for Certain Health Care Workers (the Code) does not apply. However the SA HCSCC cannot impose sanctions in the same manner as described in the Code.[360]

7.57 The SA HCSCC told the Committee how even where a service provider like the Esther Foundation fails to fall within the definition of a 'health service', the Commissioner has powers to investigate community services:

> In a small number of circumstances where a particular facility or service provider like the Esther Foundation does not fall within the definition of a health service, the [HCSC] Act also allows me the flexibility to determine whether they may instead be a community service. For the purposes of the Act, community services are subject to the same investigatory powers contained within Part 6.[361]

Application of the South Australia Code of Conduct for Certain Health Care Workers

7.58 The Code in SA applies to individual healthcare workers who are not registered under the *Health Practitioner National Law* (SA) (the National Law) or individual healthcare workers who are providing health services outside the scope of their registered profession under the National Law. The Code does not apply to organisations or business entities in their entirety.[362]

7.59 The SA HCSCC advised that:

> This restricts the ability of my office to provide effective regulation by issuing sanctions in circumstances such as those detailed [in] the allegations about the Esther Foundation or where an organisation has breached the standards set out in the Code and therefore presents a significant risk to public safety. Accordingly, I urge the committee to consider whether amendments are required to ensure the Code can be fully applied to organisations providing health services in WA.[363]

7.60 Most health practitioners and health service organisations do operate appropriately.[364] However, unscrupulous practitioners or organisations can 'find a way to become something' that is not subject to regulation.[365] It is a concern that unscrupulous organisations may seek to define themselves out of health regulations completely, promoting themselves as community service providers. There is a need to consider whether an expansion of HaDSCO's remit should include jurisdiction to investigate and have determinative powers in relation to community services, as well as health services.

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360 *ibid.*
361 Submission 44, Health and Community Services Complaints Commissioner (South Australia), p. 2.
362 *ibid.*
363 *ibid.*, p. 3.
364 Ms Sarah Cowie, Health and Disability Services Complaints Office, *Transcript of Evidence*, 3 August, p. 7.
365 *ibid.*, p. 5.

Recommendation 4

That the Minister for Health and Mental Health amends the *Health and Disability Services (Complaints) Act 1995* to provide HaDSCO with greater powers to handle complaints and concerns about organisations that provide health services. These powers should be comparable to the powers that HaDSCO will have in relation to individual healthcare workers through the implementation of the National Code of Conduct for Health Care Workers—including the ability to receive complaints, initiate own-motion investigations and issue prohibition orders.

In doing so, the Committee recommends consideration be given to:

- How HaDSCO's expanded jurisdiction in relation to organisations would complement the regulation of health services captured by the *Private Hospitals and Health Services Act 1927*.
- Whether a regulatory gap exists concerning complaints mechanisms for community services in WA, and whether it would be beneficial to broaden HaDSCO's jurisdiction to include community services.

HaDSCO's new remit will not prevent LGBTQA+ conversion practices from occurring in WA

7.61 As described in Chapter 3, we heard from former residents of the Esther Foundation that were subjected to or witnessed LGBTQA+ suppression and conversion practices. These practices are unacceptable and we recognise that measures are required to ensure that such practices do not continue to take place in WA.

7.62 Across Australia, there has been increasing recognition of the occurrence of conversion practices and the harm caused by these practices. In response, various Australian states and territories have taken steps to introduce legislation to prohibit conversion practices.

7.63 In 2018, the Victorian Health Complaints Commissioner commenced an inquiry into conversion practices. The *Report of the Inquiry into Conversion Therapy* added to the significant body of evidence that demonstrates the harmful impacts of conversion practices. The VIC HCC identified how the inquiry's findings detail 'the long-term psychological harm and distress to people who have undergone conversion therapy/practices.'[366] Several key themes were identified and summarised by the Commissioner:

- Survivors experience acute distress and/or ongoing mental health issues such as severe anxiety and depression
- Survivors experience feelings of guilt and shame about their sexuality, reporting being 'overwhelmed by guilt' and guilt that is 'always there'
- Conversion therapy/practices reinforced homosexuality as a form of 'brokenness'
- Church teachings that homosexuality is sinful
- Pressure to change a person's sexuality from gay to straight or pressure to stop acting on a person's same-sex attraction

366 Health Complaints Commissioner (Victoria), *Report on the inquiry into conversion therapy: Executive summary*, 31 January 2019, p. 2.

- Attributing 'same-sex attraction' to childhood, developmental or family issues.[367]

7.64 A 2021 research report from La Trobe University, investigating the experiences of LGBTQA+ Australians who had experienced conversion practices, further added to the body of evidence establishing the harm caused by these practices, and the support that survivors may need as a result.[368]

7.65 The Australian Medical Association (AMA), Royal Australasian College of Physicians (RACP) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) oppose psychological practices that aim to change a person's sexual orientation or gender identity.[369] The RACP President has observed that 'gay conversion therapy is unethical, harmful and not supported by medical evidence.'[370] The AMA has called for all state and territory governments to ban conversion practices.[371]

Legislation is needed to prohibit conversion practices

7.66 WA does not have legislation in place that prohibits conversion practices. Through our inquiry, we heard that conversion practices are diverse and they are occurring in a range of settings.[372]

7.67 The changes that will occur to HaDSCO's remit, through the introduction of the National Code, will empower HaDSCO to investigate certain healthcare workers who may be undertaking conversion practices. However, this does not go far enough in preventing conversion practices from occurring—specific legislation prohibiting these practices is required. This is consistent with an independent body of evidence that identifies conversion practices can fall between the gaps of regulatory frameworks for healthcare services.[373]

367 *ibid.*
368 The Australian Research Centre in Sex, Health and Society, La Trobe University, *Healing Spiritual Harms: Supporting Recovery from LGBTQA+ Change and Suppression Practices*, Melbourne, 2021, p. 4.
369 Australian Medical Association, *AMA releases new position statement on LGBTQIA+ health*, 19 November 2021, accessed 4 October 2022, <https://www.ama.com.au/>; Royal Australasian College of Physicians and Royal Australian and New Zealand College of Psychiatrists, *Doctors criticise gay conversion therapy remarks in marriage equality debate*, accessed 4 October 2022, <https://www.racp.edu.au/>.
370 Royal Australasian College of Physicians and Royal Australian and New Zealand College of Psychiatrists, *Doctors criticise gay conversion therapy remarks in marriage equality debate*, accessed 4 October 2022, <https://www.racp.edu.au/>.
371 Australian Medical Association, *AMA releases new position statement on LGBTQIA+ health*, 19 November 2021, accessed 4 October 2022, <https://www.ama.com.au/>.
372 Mr Mark Fallows, Chair, Ending Conversion Practices WA, *Transcript of Evidence*, 3 August 2022, p. 2; SOGICE Survivor Statement, July 2020, p. 3; Submission 31, Uniting Church Western Australia, p. 3.
373 The Australian Research Centre in Sex, Health and Society, La Trobe University; and Human Rights Law Centre, *Preventing Harm and Promoting Justice*, Melbourne, 2018, p. 53.

7.68 One of the key limitations in relying upon the changes to HaDSCO's remit to prevent conversion practices from occurring is that these practices do not just take place in clinical settings.[374] We heard that '…conversion therapies occur in settings that are not health-based, and so a health-based approach does not address those settings.'[375]

The most dangerous thing we could do as a result of this inquiry is to treat Esther House as if it is an isolated anomaly. Esther House is part of a tapestry of organisations, both health and non-health focused, delivering conversion practices in WA.

- Mx Charlotte Glance, Youth Pride Network

7.69 Insights from the Victorian Health Complaints Commissioner indicate that there are limitations in relying upon health complaints entities to prohibit conversion practices. The Commissioner found:

> …that without legislation to prohibit these practices, and in the absence of complainants coming forward with specific and current information, it was difficult for regulatory bodies, including [the Victorian HCC], to regulate those providers who offered conversion therapy/practices.[376]

Finding 42

Expanding the jurisdiction and powers of the Health and Disability Services Complaints Office will not prevent LGBTQA+ conversion practices in Western Australia, as these practices occur both within and outside healthcare settings.

Legislation exists in other jurisdictions

7.70 As a result of the VIC HCC's recommendations, legislation prohibiting conversion practices was introduced into Victoria. The Victorian *Change or Suppression (Conversion) Practices Prohibition Bill 2020* passed the Legislative Assembly in December 2020 and legislates to:

- Denounce and prohibit change or suppression practices.
- Establish a civil response scheme within the Commission to promote understanding of the prohibition of change or suppression practices, consider and resolve reports of change or suppression practices, and investigate serious or systemic change or suppression practices.
- To prohibit engaging in change or suppression practices, including by creating offences in relation to engaging in change or suppression practices and other related activities.
- Amend the definitions of sexual orientation and gender identity in the Equal Opportunity Act; and to include sex characteristics as a protected attribute under the Equal Opportunity Act.[377]

374 Mr Mark Fallows, Ending Conversion Practices WA, *Transcript of Evidence*, 3 August 2022, p. 8.
375 Mx Charlotte Glance, Policy and Project Coordinator, Youth Pride Network, *Transcript of Evidence*, 3 August 2022, p. 8.
376 Health Complaints Commissioner (Victoria), *Commissioner welcomes step towards new legislation to prohibit conversion therapy*, 18 January 2021, accessed 3 October 2022, <https://hcc.vic.gov.au/>.
377 *ibid*.

7.71 The Victoria Commissioner commented that during the inquiry into conversion practices, she received enquiries from the Northern Territory, ACT and Queensland Governments—the ACT and Queensland Governments have since introduced legislation to ban conversion therapy.[378] The Tasmania Law Reform Institute released a report in May 2022 recommending reforms to address the risks and harms caused by conversion practices.[379] The Tasmanian government has confirmed it will introduce legislation to ban conversion therapy in 2023.[380]

Similar legislation needs to be implemented in WA

7.72 In Victoria, the Health Complaints Commissioner observed that 'funding for counselling and psychological services, together with legislation, would provide a very clear message to the community that conversion therapy/practices are not condoned.'[381] We heard that in the context of conversion practices occurring in WA, the Victorian experience has shown that it is 'very important for government to explicitly denounce conversion practices and conversion ideology.'[382]

7.73 Although reforms for regulating health workers and health facilities will take steps toward prohibiting conversion practices in WA, it is evident that further legislation is required. The occurrence of conversion practices in WA, and the resulting harm, necessitates the introduction of legislation that will explicitly prohibit such practices.

Recommendation 5

That the Attorney General introduces legislation to prohibit conversion practices, and establish a civil response scheme and supports for survivors of conversion practices.

MR C.J. TALLENTIRE, MLA
CHAIR

378 *ibid.*
379 Tasmania Law Reform Institute, *Sexual Orientation and Gender Identity Conversion Practices: Final Report No. 32,* Hobart, April 2022.
380 Isabel Bird, 'Tasmanian Premier reaffirms commitment to ban gay and gender conversion therapy', *The Examiner* (web-based), 26 October 2022, accessed 16 November 2022, <https://www.examiner.com.au/>.
381 Health Complaints Commissioner (Victoria), *Report of the Inquiry into Conversion Therapy: Executive Summary*, Melbourne, 31 January 2019, p. 3.
382 Mx Charlotte Glance, Youth Pride Network, *Transcript of Evidence*, 3 August 2022, p. 7.

Appendix One

Committee's functions and powers

The functions of the Committee are to review and report to the Assembly on:

a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

b) annual reports of government departments laid on the Table of the House;

c) the adequacy of legislation and regulations within its jurisdiction; and

d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual reports of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

Appendix Two

Support services and the Commissioner for Victims of Crime

Support services

The following services are able to provide priority access to treatment for women impacted by the Esther Foundation. These women's health services are able to provide support for women who have complex issues including past histories of domestic violence, trauma and sexual abuse.

SERVICE	CONTACT	SERVICE DESCRIPTION/LOCATION
Here For You	1800 437 348	Here For You is a statewide confidential, telephone service for anyone concerned about their own or another person's alcohol and other drug use and/or mental health issues. They are aware of the Esther Foundation issues and would be an appropriate first point of contact as they would be able to provide support and discuss referral options with the caller. They will also be able to facilitate referrals for women who call.
Midland Women's Health Care Place	08 9250 2221	4 The Avenue, Midland, WA 6056
Women's Health and Wellbeing Services	08 9490 2258	Suite 7, Level 1, Gosnells Community Lotteries House, 2232 Albany Highway, Gosnells, WA 6110
Fremantle Women's Health Centre	08 9431 0500	114 South Street, Fremantle, WA 6160
Women's Health & Family Services	08 6330 5400	227 Newcastle Street, Northbridge, WA 6003

Commissioner for Victims of Crime

The Office of the Commissioner for Victims of Crime promotes and safeguards the interests of victims of crime in the Western Australian justice system. Their services are available to all Western Australians, wherever they live, and whatever their age, ability or disability, gender, sexuality, cultural background or personal circumstances.

Telephone: 08 9264 9877

Email: cvoc@justice.wa.gov.au

Website: www.wa.gov.au/organisation/department-of-justice/commissioner-victims-of-crime

Appendix Three

Responses from Patricia Lavater

This appendix contains Ms Lavater's responses to the complaints and allegations, and the Committee's findings, edited for brevity. These responses were given in several different contexts:

- Written submissions
- Closed hearing, and
- Email in response to final disclosure of adverse references and draft adverse findings prior to publication of the report.

Responses to complaints and allegations

The program did not always meet residents' needs and expectations

Ms Lavater told us:

> Prescribed medication was withdrawn under doctor's instructions. Typically, in the instance of Valium the resident would reduce her dosage under doctor's instructions. Valium is a very addictive drug and residents were not encouraged to remain on it. Some of our residents remained on anti-psychotic medication for the entire duration of their stay. Again, this was under doctor's orders. We had a doctor and a psychiatrist visit Esther Foundation… weekly and, in instances, residents continued to see their regular mental health workers.[383]

Emotional and psychological abuse

Ms Lavater told us:

> We did not shame residents for crying, On the contrary, our culture was to encourage and not discourage crying.[384]

She also told us that she did not personally agree with telling people they were attention seeking or making things up and she was not aware of this being said to residents, but she could not vouch for what other people involved in the program might have said. She said that there was a lot of group therapy, which she has realised 'can look like public shaming' if somebody is speaking about their issues and other people 'are allowed to speak into that.' Ms Lavater told us that, in hindsight, she 'is not sure about this kind of therapy anymore.'[385]

383 Ms Patricia Lavater, Founder and former Managing Director, Esther Foundation, Email, 24 November 2022, p. 1.
384 *ibid*.
385 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, pp. 8, 10.

Ms Lavater said:

> We would warn residents if they were leaving in the middle of the night, [they were] risking being raped or attacked. If residents were heavily addicted to drugs and leaving the program to procure drugs we would warn them about overdosing on street drugs.[386]

Religious practices

Ms Lavater said the religious requirements of the program were explained to participants during the assessment and intake process.[387] She said:

> We had Wednesday afternoon prayer meetings which were optional. There were occasional late night prayer meetings into the night. Residents were encouraged to return to their rooms at any time and when they felt like it.[388]

Ms Lavater denied practicing exorcisms because she is 'not really qualified' and 'never used that term.'[389] She said they definitely prayed for people, but this was never forced. Some residents would ask for prayer a lot, which 'used to get quite tiring'.[390]

> I definitely believe in praying for people if they are struggling, and it definitely brought peace to them when we prayed for them. Sometimes I would start praying for a young woman and she would start screaming and wailing on the floor because, obviously, she became very emotional; she was releasing a lot of torment, a lot of trauma. So that would happen. Other residents sometimes got really freaked out about that, but we would try and explain to them that they were being released from the darkness that they were encountering.[391]

LGBTQA+ suppression and conversion practices

Ms Lavater denied that the Esther Foundation talked about homosexuality as a disorder or practised conversion therapy.[392] She said women did come for prayer 'because they felt tormented about their orientation', but she did not personally believe in a 'homosexual demon.'[393] She said that regardless of residents' sexual orientation, relationships were not allowed in the program.[394]

Ms Lavater said:

- residents were never told that homosexuality was caused by demons. Also, some of the residents did not feel accepted by the general community and entered the program with suicidal ideation

386 Ms Patricia Lavater, Email, 24 November 2022, p. 1.
387 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 3.
388 Ms Patricia Lavater, Email, 24 November 2022, p. 1.
389 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 5.
390 *ibid*.
391 *ibid*., p. 11.
392 *ibid*., pp. 10-11.
393 *ibid*., p. 11.
394 *ibid*., p. 10.

- as part of the residential program, workbooks were available in the Esther Foundation library and residents could choose from a range of topics. It was a personal choice as to which book they chose to work on. There were books on marriage among many other topics
- she was not aware of any residents visiting the Court Hotel or claims of being a source of corruption
- all residents were asked not to approach each other either romantically or sexually.[395]

Ms Lavater said she could not comment on the application forms because she had left the Esther Foundation by then.[396]

Culturally harmful practices

Ms Lavater attributed these specific complaints to the issues she says the resident was experiencing at the time. She said she was not aware that any Aboriginal residents were separated from family members.[397]

Ms Lavater told us that this was a 'very confusing' allegation because she 'has a real heart for Aboriginal people' and 'to see them being restored in the community', and the Esther Foundation was 'very pro Aboriginal arts and culture.'[398] Aboriginal art was encouraged during creative groups and this was displayed and sold at exhibitions.[399] Groups visited an Aboriginal organisation in Broome 'to help and to find out more about Aboriginal culture.'[400] Ms Lavater said that Aboriginal dance was encouraged and Aboriginal residents were very happy to show everyone their dancing at the time. She said they were not aware that anyone was making fun of their cultural dancing, but 'there might have been some mocking from other residents' who could be 'very hard on each other.'[401]

Medical complaints

Ms Lavater said that the Esther Foundation 'relied heavily on doctors' because 'we were never a medical program, and a doctor visited once or twice a week.[402] They would 'ask for help' for women detoxing off drugs and these residents 'were often given antipsychotics' and 'given a routine of how to slowly come off.'[403] For safety, prescribed medication was kept in a safe and handed out at certain times' 'the girls were not always happy with that.'[404] Ms Lavater said that residents probably would not have realised that they would call a doctor if residents were 'really struggling' and the doctor would sometimes advise them to 'give them extra Seroquel or extra valium to help them.'[405]

395 Ms Patricia Lavater, Email, 24 November 2022, p. 2.
396 *ibid*.
397 *ibid*.
398 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 11.
399 Closed Submission 64, Ms Patricia Lavater, p. 5.
400 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 11.
401 *ibid*., p. 12; Ms Patricia Lavater, Email, 24 November 2022, p. 2.
402 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 7.
403 *ibid*.
404 *ibid*., p. 8.
405 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 7.

Ms Lavater said:

- 'we were not aware that anyone's medication was suddenly withdrawn from them. Withdrawal of medication only occurred under doctor's orders'
- 'staff and residents often chatted to each other and looked up Google internet searches to match symptoms to health conditions but this was not ever considered a professional diagnosis to be acted upon. Nor was it ever a replacement for a doctor's diagnosis'
- 'we had health care workers visiting Esther [Foundation] and the girls were also taken to medical centres for treatment. This included Royal Perth Hospital, Charles Gardiner Hospital and Bentley Hospital for both physical and mental health issues. There are official records to confirm this.'[406]

Lack of structured program

Ms Lavater said that the no-contact period was explained to residents at their assessment meeting and was necessary to minimise distractions, allow residents to cut connections with negative influences and abusive relationships, reduce risk of buying contraband substances or items and reduce flight risk for high-risk participants. After this period, 'providing no relapse', this restriction would be reduced in stages according to the residents' personal progress and assessed risk.[407] Ms Lavater said that often if residents left or used drugs or committed crimes while they were in the program, they would re-commence their induction program but not necessarily for 30 days—only until they re-settled.[408]

Ms Lavater told us that they would only graduate residents if they had been able to prove certain achievements, and it could be delayed if residents relapsed. She also said that 'graduation was not really an expected thing for all of the young women to be able to achieve.'[409] She said that graduation ultimately depended upon a team of staff making recommendations to her.[410]

Ms Lavater said that longer-term residence was an advantage for many program participants but, 'in hindsight, yes, they probably do get institutionalised after that longer period of time.' She told us 'I do not really agree with that anymore because I feel like they were in a bubble.' She said that she realised residents 'became very dependent on us like parents and then there becomes this resentment that as their parents or as their authority, we are keeping an eye on everything they do.'[411] She said it was the exception rather than the norm that some residents stayed for years and 'they volunteered to stay.'[412]

406 Ms Patricia Lavater, Email, 24 November 2022, p. 2.
407 Closed Submission 64, Ms Patricia Lavater, p. 7.
408 Ms Patricia Lavater, Email, 24 November 2022, p. 3.
409 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, pp. 5-6.
410 Ms Patricia Lavater, Email, 24 November 2022, p. 3.
411 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 5.
412 Ms Patricia Lavater, Email, 24 November 2022, p. 3.

Inappropriate responsibility given to residents

Ms Lavater said that they encouraged residents to look out for each other as part of the 'buddy/angel' system, particularly during detoxing. She said if a resident ran away and they were in the middle of a crisis, then on a 'one-off' occasion, an underage resident may have been asked to look after the house but only for a very short period. This was not relied upon as an ongoing practice. She said it was at the discretion of mothers in the program with young children to arrange for other residents to babysit their children while they went out or had an overnight stay elsewhere and 'this was nothing to do with Esther [Foundation].'[413]

Ms Lavater recognised that there 'could have been a problem' with inadequately skilled or qualified staff.[414] She told us that as the Esther Foundation grew, the process of becoming a participant leader became stricter and involved better training.[415]

Education

Ms Lavater told us that they were required to demonstrate to the education department that residents under 16 were doing some sort of schooling. Residents were 'not as keen' on online schooling, and a professional teacher came in.[416]

Ms Lavater said that the online education provider had trained tutors online and the secretary was not the tutor. Residents were encouraged to do TAFE courses but not all were permitted to do face-to-face campuses because of their vulnerabilities. Online courses were always available, including bible college.[417]

Family alienation

Ms Lavater told us that families were encouraged to be involved with the Esther Foundation as much as possible. After the initial 30-day period, participants could have weekly phone calls with their families, as well as contact via their case manager. In person visits and overnight stays were allowed later on a case-by-case basis.[418] Younger residents had phone calls and letters monitored because of tensions and arguments with their parents. Ms Lavater said she was not aware of anyone who was not permitted to visit a dying family member.[419]

Ms Lavater said that residents were advised that their parents had dropped them off at the Esther Foundation because of the relationship breakdown in the home.[420] Ms Lavater also said that families were often desperate for help or terrified of having a resident back to their home, so they forced their child to attend the Esther Foundation or requested a slower process for beginning meetings with their child so 'they could slowly work their way back into trust.' Ms Lavater said that some residents may have taken this as their family not

413 Ms Patricia Lavater, Email, 24 November 2022, p. 3.
414 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 5.
415 Closed Submission 64, Ms Patricia Lavater, p. 10.
416 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 7.
417 Ms Patricia Lavater, Email, 24 November 2022, p. 3.
418 Closed Submission 64, Ms Patricia Lavater, p. 8.
419 Ms Patricia Lavater, Email, 24 November 2022, p. 3.
420 *ibid*., p. 4.

wanting them. She also said that some underage residents were returned by police against their will when their parents refused to have them and police 'did not have anywhere else to put them.'[421]

Physical restraints and assaults

Ms Lavater said she had never seen a resident tied to a bed, and recalled one incident where a resident with extreme tendency to self-harm was monitored for a few hours by tying her to a staff member with a piece of wool, by consent. She said 'whether it looks like it was something wise to do or not, I do not know, but we were trying to save the girl's life.'[422]

Ms Lavater said she was not aware of any resident being slapped.[423] She said that physical restraint was used, but only as a last resort to protect someone in extreme circumstances such as attempted suicide, self-harm or intent to harm others, or absconding 'at an unreasonable hour.'[424] She said they were mindful of their duty of care to try to stop residents leaving the program who were 'psychotic' or in crisis. She cited some extreme examples of residents who tried to run away and posed a danger to themselves or the community. The Esther Foundation would call the police who supported staff acting to keep the resident and the community safe, even if this meant using physical restraint. Ms Lavater also said that police often brought back residents who had run away because 'they felt the Esther Foundation was a safe place for young women.'[425]

Ms Lavater told us that none of the bedroom doors had locks due to high-risk participants and that room checks were performed regularly as a safety precaution and to ensure residents' participation in the program.[426]

Sexual assault

Ms Lavater responded that she 'definitely was never aware that anyone was sexually assaulted.' She said that one former resident had contacted her after she left the Esther Foundation to raise an allegation of sexual assault and she suggested that the resident go to the police.[427]

Other complaints

Ms Lavater said:

> I was not aware of any financial irregularities and this happening but the workers may have assisted the residents with their banking. Residents worked in the café and our other social enterprises for training purposes. They gained experience under supervision. Residents were asked to be involved in a work period where

421 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 6.
422 *ibid*., p. 12.
423 Ms Patricia Lavater, Email, 24 November 2022, p. 4.
424 Closed Submission 64, Ms Patricia Lavater, p. 9.
425 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, pp. 9, 13.; Closed Submission 64, Ms Patricia Lavater, p. 9.
426 Closed Submission 64, Ms Patricia Lavater, p. 6.
427 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 13.

there was physical labouring in the gardens and the houses for one afternoon a week and occasionally Saturday mornings. This was an expectation living in a residential home. The kind of exercise expected of residents included walking up and down the nearby hill or on the river banks.

Health and weight were talked about in health classes. This came about due to many young women complaining about their weight gain due to the amount of food readily available in the program. It was a known fact that Esther provided amazing home cooked meals which included a high standard of healthy food. There was always food available for snacks in between meals.

The Esther program was run like a family and older residents were encouraged to be sisters to the younger ones. There was not a separation of age groups per se, but it was always discussed at length of the appropriate and compatible cohorts living at each house. Difficult residents resided at the main house where senior workers were working and monitoring.[428]

Responses to findings

Nepotism compromised the organisation's governance

Ms Lavater told us there were many different ways that residents could complain, including via a complaints box, through clinical staff and the chaplain, or by writing a letter to her.[429]

Ms Lavater also told us that the Esther Foundation was not closed; rather, it had a lot of community involvement and was being visited and scrutinised all the time. Given this, she told us that 'it just seems strange that nobody ever heard any of those complaints at the time.'[430]

Governance was weak and there was little accountability

Ms Lavater said that there were 'some very strong voices' on the Esther Foundation board; if they disagreed with her, they would discuss this and put new policies and practices in place.[431]

Staff were inadequately qualified and had no external experience

Ms Lavater said that she and other senior workers had qualifications and had been involved with different agencies. However, she told us that for residents who became workers, the Esther Foundation would have been their main place of work. These workers were encouraged to do practical training in other organisations.[432]

428 Ms Patricia Lavater, Email, 24 November 2022, p. 4.
429 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 13.
430 *ibid*., p. 16.
431 *ibid*., p. 14.
432 *ibid*., pp. 14-15.

Lack of professionalism

Ms Lavater told us that there were a lot of policies and procedures, some of which were put together with help from an external organisation. When the federal government grant was secured, 'even more stringent box ticking' was required, which is when the new CEO was employed 'to do all of that.'[433]

Faith-based practice was a substitute for evidence-based treatment

Ms Lavater said that the main faith-based practices happened in the church services, although the 12-step program did run on biblical principles.[434]

Patricia Lavater was a singular, dominant influence

Ms Lavater said that she is a 'strong person', and 'you would have to be a strong person to grow an organisation over 28 years and for it to become the organisation that it did in a million-dollar facility.' Although she claimed that staff in meeting could be 'very strong' to speak to her if they did not agree with anything, Ms Lavater also said that 'it could be true that people wanted to please me rather than come up against me' and people may have been fearful to speak to the CEO.[435]

433 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, p. 15.
434 *ibid*., p. 15.
435 Ms Patricia Lavater, *Closed Transcript of Evidence*, 21 September 2022, pp. 15-16.

Appendix Four

Responses from former Esther Foundation board representatives, and interim CEO

This appendix contains responses from the former Esther Foundation board representatives and interim CEO, to the extent that they discussed some of the complaints and allegations in the closed hearing they attended with the Committee. In one instance below, this is supported by evidence from the former Chief Executive Officer, Mrs Anina Findling.

Prior to publication of the report, we disclosed a full version of the adverse references and draft adverse findings to the former board representatives and interim CEO and gave them an opportunity to respond. They advised 'we have no additional comments to provide at this stage'.[436]

Religious practices

The former board Chairperson said the religious requirements of the program were explained to participants during the assessment and intake process.[437] However, the former interim CEO said there was a degree of 'peer pressure' to the religious model of the program and that incoming residents were unlikely to understand at the outset what exactly that would involve 'day to day'.[438] The former board Chairperson told us 'in the older times… probably, there was an element of coercion: "we're all off; we are all going [to a chapel service]."'[439]

Former board representatives told us that they had not seen any extreme religious practices; they were 'never a part of the program', 'historical' and 'should have ceased.'[440]

LGBTQA+ suppression and conversion practices

Former board representatives told us that they routinely knew of residents who identified as LGBTQA+ and 'they were welcome and respected whatever their sexual orientation', 'it was not really an issue, it was just part of who they were.' They said that conversion practices were not supported as part of the Esther Foundation program and although they did not witness these practices, they accepted that 'it possibly happened' and 'clearly, some people have been really hurt.'[441]

436 Mrs Annette Latto, Former Chairperson, Esther Foundation, Email, 23 November 2022.
437 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 18.
438 Mr Philip Sparrow, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 18.
439 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 18.
440 Mrs Annette Latto & Mr Jeroen Bruins, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, pp. 16, 18.
441 *ibid*., pp. 18-19.

Lack of structured program

The former board Chairperson told us that institutionalisation and residents struggling to adapt after a lengthy stay in the program had been identified as a problem.[442]

Inappropriate responsibility given to residents

The former interim CEO told us that while an intern system has some benefits and is 'not inappropriate if there is adequate supervision and support', this was not the case at the Esther Foundation – 'there were some girls who were working in a capacity for which they probably were not really skilled.' This was 'not catastrophic' but 'made some difficulties.'[443] The former board Chairperson said that, for some residents, taking on responsibilities as interns may also have impeded them from addressing their own issues.[444]

Sexual assault

The former board Chairperson told us that in 2019, when the organisation began receiving complaints, no allegations of sexual assault were raised with them directly.[445] This accords with evidence given to us by the former Chief Executive Officer.[446]

The former Chief Executive Officer also told us that she read Facebook posts that a 'detective investigation' was underway but the organisation was of the view that it would be inappropriate for them to take any action and they should 'let that take its course'.[447]

442 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 4.
443 Mr Philip Sparrow, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 5.
444 Mrs Annette Latto, Esther Foundation, *Closed Transcript of Evidence*, 28 June 2022, p. 5.
445 *ibid*., p. 9.
446 Closed Submission 60, Mrs Anina Findling, p. 3.
447 *ibid*., p. 4; Mrs Anina Findling, *Closed Transcript of Evidence*, 28 June 2022, p. 12.

Appendix Five

Government support for the Esther Foundation

As outlined in the report, safety and quality requirements apply when government agencies procure AOD treatment and mental health services. We heard that in the case of the Esther Foundation, these requirements did not apply because the organisation did not receive any funding for service provision.

WA Government agencies submitted that they did not provide operational funding to the Esther Foundation, nor had any remit or official relationship to the Foundation.[448] However, Government agencies did provide support to the Foundation in the form of the acquisition and physical premises for the Foundation, small grants, referrals, and placements of individuals to the foundation.

St. Emilie's convent and Maida Vale purchases

The most significant support the WA Government provided to the Esther Foundation was the purchase of a former Kalamunda convent, St Emilie's. Between 2007–10 the Foundation applied for various premises to house up to 50 people. In 2010, it identified the Kalamunda block and the Housing Authority subsequently purchased the site for $3.9 million, and leased it to the Foundation as an accommodation facility.[449] Communities submitted that prior to the purchase the then Premier Hon. Colin Barnett MLA had 'requested that the Housing Authority help the Esther Foundation locate a suitable facility.'[450] Funding came through the State's Crisis Accommodation Program, which allowed for the Department of Housing to purchase or build properties to then lease to non-profit community and welfare organisations.

The Foundation was initially responsible for refurbishing, administering, and maintaining the premises.[451] However, a major Lotterywest grant was later made conditional on having a suitable housing provider lead the project.[452] Community Housing Limited (CHL) subsequently applied to Lotterywest for funding to refurbish the property and in December 2012, then-Premier Barnett approved a $3.447 million Lotterywest grant.[453] In June 2016, Communities, the Foundation, and CHL formally replaced the original lease between the Housing Authority and the Foundation with a 10-year, $1 per annum lease between the Housing Authority and CHL. CHL then sub-leased the property for the same period to the

448 Submission 50, Department of Communities, p. 18.
449 *ibid.*, pp. 9-10.
450 *ibid.*, p. 10.
451 *ibid.*, p. 8.
452 *ibid.*, p. 10; WA Government, *Former convent given a new lease of life*, media release, 20 November 2010.
453 Submission 50, Department of Communities, p. 11; WA Government, *St Emilie's offers shelter to support young women in need*, media release, 22 June 2018; Community Housing Group Ltd, *Newly refurbished convent site in Kalamunda now restoring lives in need*, 22 June 2018, accessed 12 September 2022, <https://chl.org.au/>.

Esther Foundation at $1,000 per annum per bedroom, indexed annually to the CPI.[454] Communities submitted that as that lease was between CHL and the Foundation the Housing Authority had no direct rights of termination.[455] In 2016, Communities contributed a further $200,000 to the fit-out. In 2017, Lotterywest provided an additional $324,000 to develop a multi-use court and security fencing onsite.[456] Lotterywest elsewhere claimed it provided more than $4.2 million in total grants to the project.[457] The 20-bedroom crisis accommodation facility, catering for up to 40 women, opened in June 2018.[458]

Following the Foundation's stated need for further accommodation, in July 2018 the then-Minister for Housing, Hon Peter Tinley AM MLA, approved the Housing Authority's purchase of a five-bedroom property in Maida Vale for $790,000, as part of the Crisis Accommodation Program.[459] Communities provided a further $159,000 to maintain and upgrade the property and leased it directly to the Esther Foundation at the peppercorn rent of $1 per year.[460]

Grant funding

In addition to support relating to the above properties, State Government agencies, primarily Communities, provided numerous other grants to the Foundation:

- 2007: $3,300 from Communities for the Youth Grants WA Program – Dance Project.[461]
- 2008: $1,500 initiative for school holiday programs. The Foundation was one of 33 organisations receiving similar amounts of funding.[462]
- 2009: $5,500 from Communities for the Youth Grants WA Program - Run to Freedom - Health development program.[463]
- 2011: $20,000 – Communities Discretionary Grant – Annual Winter Camp.[464]
- 2010–11: $113,832 approved through the Royalties for Regions programme for the Foundation's Esther South West Project.[465]

454 Submission 50, Department of Communities, pp. 11-12.
455 *ibid.*, p. 12.
456 *ibid.*, p. 8; WA Government, *St Emilie's offers shelter to support young women in need*, media release, 22 June 2018; Community Housing Group Ltd, *Newly refurbished convent site in Kalamunda now restoring lives in need*, 22 June 2018, accessed 12 September 2022, <https://chl.org.au/>.
457 Lotterywest, *A safe place for young women in Kalamunda*, 24 July 2018, accessed 13 September 2022, <https://www.lotterywest.wa.gov.au/>.
458 WA Government, *St Emilie's offers shelter to support young women in need*, media release, 22 June 2018; Submission 50, Department of Communities, p. 10.
459 Submission 50, Department of Communities, pp. 11-12.
460 *ibid.*, p. 12.
461 *ibid.*, p. 8.
462 WA Government, *Youth to enjoy more school holiday activities*, media release, 3 December 2008.
463 Submission 50, Department of Communities, p. 8; WA Government, *Western Australian youth organisations to receive $29,000 funding*, media release, 13 February 2009.
464 Submission 50, Department of Communities, p. 8.
465 Department of Regional Development and Lands, *Royalties for Regions: Progress Report July 2011-June 2012*, WA Government, November 2012, p. 182.

- 2012: $2,760 from Health provided for Drug Aware T-shirt printing.[466]
- 2014: $25,000 – The Department for Child Protection and Family Support Discretionary Grant – to assist with relocation expenses.[467]
- 2014: $25,000 – The Department of Local Government and Communities Discretionary Grant from the WA Family Foundation to assist with operational expenses.[468]

Referrals and placements

Though the relevant data is imperfect, several agencies provided evidence of having made referrals.

Communities said it has 'a central contact list of suitable referral agencies and services' and any referrals to the Esther Foundation 'would have been made through Statewide Referral and Response Services within Communities, and through Communities' offices.'[469] It noted that though simply providing contact lists to clients 'would not be considered either a formal referral or a placement by Communities' these lists have been used and distributed 'for a number of years.'[470]

Communities also said its data search found that '15 young people in the care of Communities' Chief Executive Officer … may have resided at Esther Foundation' between 2005 and 2020', and mostly within the first five years.[471] Of these, Communities formally referred five, and endorsed another self-referral. For the other nine, Communities could not determine whether it endorsed a self-referral or had initiated the referral.[472] It said references to Esther House were removed from service directories on 11 March 2022, and on 12 April 2022, due to 'recent allegations of a criminal nature in relation to Esther Foundation' all Community Services staff were directed to cease referrals to the Foundation.[473]

The Department of Health gave evidence that, as opposed to Health Service Providers (HSPs), it does not make referrals.[474] It accepted it has 'no central data source to identify HSP patient referrals to the Foundation and a comprehensive review would require an extensive manual review of patient notes.' However, it knew of five patients referred by Health Service Providers 'in the past few years', and of these two had been accepted into the Esther Foundation.[475]

The Department of Justice provided 41 official referrals to the Foundation through Melaleuca Women's Prison between April-November 2021, including 32 Aboriginal or Torres

466 Submission 65, Department of Health, p. 3.
467 Submission 50, Department of Communities, p. 8.
468 *ibid.*, p. 8.
469 *ibid.*, p. 5.
470 *ibid.*, p. 6.
471 *ibid.*, p. 6.
472 *ibid.*, pp. 6-7.
473 *ibid.*, p. 7.
474 Mrs Vanessa MacDonald, Department of Health, *Transcript of Evidence*, 10 August 2022, p. 8.
475 Submission 65, Department of Health, p. 3.

Strait Islander people.[476] One Justice service provider identified an additional referral.[477] However, Justice also acknowledged that 'the 42 identified referrals cannot be considered comprehensive as informal comments to prisoners by Departmental staff and others could be interpreted as a referral outside of a formal referral process' and that 'there is no data capture and extraction method available to identify every referral to the Esther Foundation with certainty.'[478] Justice said following advice from Communities, between 30 March and 4 April 2022 it instructed staff and service providers to cease referrals to the Foundation.[479]

Australian Government grant funding

In June 2019, a grant agreement was entered into between the Australian Department of Health and the Esther Foundation, whereby the Foundation would receive $4 million over 2019–25 as part of the Australian Government's Community Health and Hospitals Program.[480]

Although we did not receive direct evidence to the inquiry concerning the provisions of the agreement, the Australian Department of Health released documents as a Freedom of Information (FOI) disclosure, outlining arrangements for the grant funding to the Esther Foundation. The agreement between the Department of Health and Esther Foundation identifies that the funding was intended to contribute to:

1. Supporting the ongoing delivery costs of the program in Western Australia.
2. Providing funding for the strengthening of the organisational structure of the Foundation and
3. Enabling the Foundation to work towards increasing its capacity by 20 places.[481]

Neither the agreement, nor the subsequent variation made to the original agreement, sought to embed sector specific quality requirements as part of the grant funding requirements.

476 Submission 48, Department of Justice, p. 2.
477 *ibid.*, p. 2.
478 *ibid.*, pp. 2-3.
479 *ibid.*, p. 3.
480 Australian Department of Health, *Commonwealth Standard Grant Agreement between the Commonwealth represented by Department of Health and The Esther Foundation Incorporated*, June 2019, pp. 3-4 and p.5, accessed 27 September 2022 <https://www.health.gov.au/>.
481 *ibid*, pp. 3-4.

Appendix Six

Submissions received

No.	Name	Position	Organisation
1	Closed submission		
1A			
1B			
2	Closed submission		
2A			
3	Closed submission		
3A	Closed submission		
4	Closed submission		
5	Closed submission		
6	Closed submission		
7	Closed submission		
8	Closed submission		
9	Closed submission		
10	Closed submission		
11	Closed submission		
11A			
12	Closed submission		
12A			
13	Closed submission		
14	Mrs Annette Latto	Former Chairperson	Esther Foundation
	Mr Jeroen Bruins	Former Board Member	
	Mr Philip Sparrow	Interim Chief Executive Officer	
15	Closed submission		
16	Closed submission		
17	Closed submission		
18	Closed submission		
19	Closed submission		
20	Closed submission		
21	Closed submission		
22	Closed submission		
23	Closed submission		
24	Closed submission		

25	Closed submission		
26	Mr Ian Carter AM	Acting Director Advocacy Commissions	Anglican Diocese of Perth
27	Mrs Simone Henriksen	Associate Lecturer in Law	University of the Sunshine Coast
28	Closed submission		
29	Closed submission		
30	Ms Wendy Hendry	Convenor	Equal Voices Western Australia
31	Mr Geoffrey Bice	Executive Officer Social Justice	Uniting Church in Australia, Synod of Western Australia
32	Closed submission		
33	Professor Nicole Lee	Chief Executive Officer Adjunct Professor	360Edge Pty Ltd National Drug Research Institute, Curtin University
34	Mr Graham Droppert SC	National President	Australian Lawyers Alliance
35	Ms Tamara Cavenett	President	Australian Psychological Society
	Dr Zena Burgess FAPS FAICD	Chief Executive Officer	
36	Mx Charlotte Glance	Policy and Project Coordinator	Youth Pride Network
	Mr Mark Fallows	Chair	Ending Conversion Practices WA
37	Mr Alex Arpino	Development Coordinator	Alcohol and Other Drug Consumer and Community Coalition
38	Closed submission		
	Closed submission		
39	Closed submission		
40	Closed submission		
41	Mr Charles Chu	Social Policy and Advocacy Officer	Australian Association of Social Workers
42	Closed submission		
43	Ms Suzanne McNeill	Principal Officer	Office of the Health Complaints Commissioner
44	Associate Professor Grant Davies	Health and Community Services Complaints Commissioner	Health and Community Services Complaints Commissioner – South Australia
45	Ms Sarah Cowie	Director	Health and Disability Services Complaints Office – Western Australia
46	Closed submission		
47	Closed submission		
48	Dr Adam Tomison	Director General	Department of Justice

49	Adjunct Professor Debora Picone AO	Chief Executive Officer	Australian Commission on Safety and Quality in Health Care
50	Mr Mike Rowe	Director General	Department of Communities
50A			
51	Closed submission		
51A			
52	Ms Rebecca Smith	Chief Executive Officer	Centre for Women's Safety and Wellbeing
53	Closed submission		
54	Closed submission		
55	Closed submission		
56	Barry Cosker	Chair	Living Proud
57	Misty Farquhar OAM		Rainbow Futures WA
58	Mr Ethan James	Manager Advocacy and Systems	Western Australian Network of Alcohol and other Drug Agencies Western Australian Association for Mental Health
59	Mr Hunter Gurevich	Chairperson	Transfolk of WA Incorporated
60	Mrs Anina Findling	Former Chief Executive Officer at the Esther Foundation	
60A			
61	Ms Dorota Siarkiewicz	Acting Health Complaints Commissioner	Health Complaints Commissioner - Victoria
62	Ms Claire Celia	Senior Policy and Advocacy Officer	The Royal Australasian College of Physicians'
63	Closed submission		
64	Ms Patricia Lavater	Founder and former Managing Director at the Esther Foundation	
64A			
65	Ms Elysia Washer	Senior Project Officer	Department of Health
66	Ms Jennifer McGrath	Commissioner	Mental Health Commission
67	Closed submission		
68	Closed submission		
69	Closed submission		
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111	Closed submission		

Appendix Seven

Hearings and briefings

Date	Name	Position	Organisation
11 May 2022 (briefing)	Closed briefing	Registered Psychologist	Access Wellbeing Services
19 May 2022 (briefing)	Dr Christina Bertilone	Acting Executive Director, Patient Safety and Clinical Quality	Department of Health
	Ms Lynda Campbell	Manager, Licensing and Accreditation Regulatory Unit	
	Mr Lindsay Hale	Deputy Commissioner	Mental Health Commission
	Ms Dace Tomsons	Manager, Country Services	
	Ms Lina Lombardini	Assistant Director, Support Services Management	
	Mr Iain Hill	Director, Treatment Services	
28 June 2022	Mrs Anina Findling	Former Chief Executive Officer at the Esther Foundation	
28 June 2022	Mrs Annette Latto	Former Chairperson	Esther Foundation
	Mr Jeroen Bruins	Former Board Member	
	Mr Philip Sparrow	Former Interim Chief Executive Officer	
6 July 2022	Closed hearing		
6 July 2022	Closed hearing		
6 July 2022	Closed hearing		
3 August 2022	Ms Sarah Cowie	Director and Chief Executive Officer	Health and Disability Services Complaints Office
	Ms Rachel Beard	Deputy Director	
	Mr Kieran Handmer	Projects Officer	
3 August 2022	Mr Mark Fallows	Chair	Ending Conversion Practices WA
	Mx Charlotte Glance	Policy and Projects Coordinator	Youth Pride Network
3 August 2022	Professor Nicole Lee	Expert Consultant	360Edge
3 August 2022	Mr Alex Arpino	Development Coordinator	Alcohol and Other Drug Consumer and Community Coalition
	Miss Alexandra Campbell	Systemic Advocacy Officer	

10 August 2022	Dr Robyn Lawrence	Assistant Director General, Clinical Excellence	Department of Health
	Dr Christina Bertilone	Acting Executive Director, Patient Safety and Clinical Quality	
	Mrs Vanessa MacDonald	Principal Consultant, Licensing and Accreditation Regulatory Unit	
10 August 2022	Mr Lindsay Hale	Deputy Commissioner, Operations	Mental Health Commission
	Mr Iain Hill	Director, Treatment Services	
17 August 2022	Ms Jill Rundle	Chief Executive Officer	Western Australian Network of Alcohol and other Drug Agencies
	Mr Ethan James	Manager, Advocacy and Systems	
	Ms Taryn Harvey	Chief Executive Officer	Western Australian Association for Mental Health
	Mr Colin Penter	Policy and Projects Officer	
30 August 2022	Closed hearing		
6 September 2022	Closed hearing		
6 September 2022	Closed hearing		
6 September 2022	Closed hearing		
6 September 2022	Closed hearing		
21 September 2022	Ms Patricia Lavater	Founder and former Managing Director at the Esther Foundation	

Appendix Eight

Acronyms

ACNC	Australian Charities and Not-for-profits Commission
Ahpra	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AOD	Alcohol and Other Drug
AODCCC	Alcohol and Other Drug Consumer and Community Coalition
CHL	Community Housing Limited
HaDSC Act	Health and Disability Services (Complaints) Act 1995
HaDSCO	Health and Disability Services Complaints Office
HCE	Health Complaints Entity
LARU	Licensing and Accreditation Regulatory Unit
LGBTQA+	Lesbian, Gay, Bisexual, Transgender, Queer, Asexual
MHC	Mental Health Commission
NGO	Non-Government Organisation
NQF	National Quality Framework for Drug and Alcohol Treatment Services
NRAS	National Registration and Accreditation Scheme
NSMHS	National Standards for Mental Health Services
NSW HCCC	New South Wales Health Care Complaints Commission
PHHS Act	Private Hospitals and Health Services Act 1927
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SA HCSCC	South Australian Health and Community Services Complaints Commissioner
VIC HCC	Victorian Health Complaints Commissioner
WANADA	Western Australian Network of Alcohol and other Drug Agencies
WAAMH	Western Australian Association for Mental Health

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