ALCOHOL AND DRUG AUTHORITY AMENDMENT BILL 2014

Second Reading

Resumed from 14 May.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [7.01 pm]: I take great pleasure in standing to speak on the Alcohol and Drug Authority Amendment Bill 2014 this evening. In doing so, I will say that I am leading the debate but I am not the lead speaker; however, I want to take some time to discuss the details of this bill. I should say from the outset that we on this side of the house will support the bill, but obviously, as with much of the legislation that comes before this place, we have questions that we would like to ask and issues that we want clarified. I also note that the minister has proposed an amendment to the bill, so we will have an opportunity in consideration in detail to examine further any issues that are not clarified in the second reading debate.

Essentially, this bill is about combining the offices of the Mental Health Commission and the Drug and Alcohol Office. I guess it is an attempt to marry the two main components of the portfolio in mental health, so the bill itself is rather mechanical in action but, like many bills, it exposes a particular policy response that is of greater concern to me than the actual processes of the amalgamation. This bill will eliminate the Drug and Alcohol Office as a statutory authority. The Drug and Alcohol Office, its functions and its staff will come under the Mental Health Commission and in doing so the board of the Drug and Alcohol Office will cease to exist—the chairmanship of that board and the other roles in it—and its statutory independence as an authority will cease to exist as well. Essentially, this will nestle the staff and functions of the Drug and Alcohol Office inside the Mental Health Commission under a chief executive officer rather than a director of the Drug and Alcohol Office. A statutory authority operates within the policy framework of the government but at arm's length of the government—I suppose is a way to describe it—to implement the policies and programs that fall under its remit. It has a separate life from departments that simply have a minister and a director general. As such, I think this bill is symbolic of a range of measures that this government is taking to rein in the independence of some sections of the public sector in order to bring it more in line with a classic departmental approach, rather than what we have here, which is a statutory authority approach. A statutory authority is not subject to the day-to-day instruction of the minister; a statutory authority operates under its own legislation and has a level of independence in the way it goes about implementing its programs. That will go; that will disappear.

The old DAO will function under the Mental Health Commission. It will be a combined element, if you like; it will be a department inside the Mental Health Commission. Obviously, that gives rise to some concerns within the sector. There are people who are anxious that this will mean that the identity of the drug and alcohol area will be lost and subsumed to the higher priorities that might be prevalent within the Mental Health Commission. There are concerns that this will take what is a good public sector practice that allows specialists and those people who are involved to drive the clinical processes around drug and alcohol services and rein them in to become, essentially, public servants. It is incumbent upon the government to reassure us and people in the sector that this is not about the process of stripping services out of drug and alcohol services to place them in the washing machine of the Mental Health Commission. The government needs to reassure us that it is not about taking the emphasis, services and resources away from drug and alcohol services, but is in fact about what the government says it is trying to do, which is to improve the coordination between drug and alcohol services and mental health services.

The Drug and Alcohol Office has roughly over 200 full-time equivalent staff and the Mental Health Commission has roughly under 200 people working inside it at the moment. The Mental Health Commission will consume the Drug and Alcohol Office, which is actually bigger than the commission. It is an interesting approach in that we will see a larger statutory authority consumed by a smaller one. I cannot help but wonder whether this is not part of an agenda by the government and the Minister for Mental Health to try to expand her particular realm, expand the size of the department that she operates, rather than what would be a considered response to the issues of drug and alcohol services and the comorbidity issues that exist with mental health. It is a curious response to what is a deep and complex public policy area; therefore, I think it is very reasonable for people in that sector to be concerned and worried about what the future holds for them.

We have had some indication from the government as to why it is going about the task of amalgamating the Mental Health Commission and the Drug and Alcohol Office. In an estimates hearing in the other place, the minister said that the decision to merge was mostly around the improved effectiveness of the services provided to people with comorbidity. Further, the Mental Health Commissioner said that the rationale behind the merger between the Mental Health Commission and the Drug and Alcohol Office is in response to the Stokes review recommendations around working more closely and in a more collaborative, integrated way in dealing with service provision to those who have coincidence occurrence of mental health issues and alcohol and drug issues.

That gives rise to two questions: the first is whether that is an appropriate response to Professor Bryant Stokes' review that was undertaken in 2012 and the second is whether it provides an appropriate rationale for combining drug and alcohol services and mental health services. I refer to what Professor Stokes said when he discussed the Drug and Alcohol Office in his report. It is clear that the main concern in his analysis was the integration or coordination of emergency department services, mental health services and drug and alcohol services and not necessarily the issue of comorbidity. In the instances when there is comorbidity, clinicians should work together to ensure that they do not provide a fragmented service. For instance, Professor Stokes states —

> D & A office build capacity within other services such as WA Police, Corrective Services, Child Protection and mental health services by providing formal and informal education in the course of their day-to-day work. Memorandums of Understanding (MOUs) between services clarify roles and processes.

Later in that section of the report Professor Stokes states —

> Improved liaison between mental health and D & A services and worker willingness to cooperatively provide care and intervention for patients with dual conditions must be enabled and encouraged.

However, nowhere does Professor Stokes state that we should combine the services of the Drug and Alcohol Office with the Mental Health Commission. In this section about the governance of drug and alcohol services it is clear that Professor Stokes' main concern is to do with emergency departments and other areas of the health system joining services for those comorbidities. It was not around the work of the Mental Health Commission and the Drug and Alcohol Office. It is simply not valid for the government to say that merging the Drug and Alcohol Office with the Mental Health Commission is in response to the Stokes review. At no point does Stokes state in any of his recommendations that we should merge the two authorities. He refers to the provision of services and making sure that they are joined, but he also refers to that in relation to corrective services, police and other areas of government. Professor Stokes does not call for the amalgamation of the Mental Health Commission and the Drug and Alcohol Office. The minister touches very briefly on this in his second reading speech, but I think it is incumbent on the government to explain why these two instrumentalities should be combined. There is no evidence to suggest that merging them would improve the delivery of these sorts of services.

I note that the Mental Health Commissioner said during the estimates committee hearing that part of the shift in the amalgamation process is —

> ... significant enhancement of the policy and procurement areas and also a significant increase in dedication of resource to consultation and engagement with consumers, carers, families and significant others in the formulation and co-design of programs.

Again, there is no indication of how merging the two authorities will bring about that. It seems to me that the government has an idea that it wants to combine the two entities—I think that is because the minister wants to grow her empire—but I have not seen any evidence from the government that that will be successful. This measure has taken place in other states, so I assume, therefore, that we are following their lead. I can see that perhaps that provides a kernel of thought that this could be a way to move forward, but I will come back to that in a second. In June the minister said in her evidence—

> It is estimated that 70 per cent of people in residential care have comorbidity and that between 30 per cent and 50 per cent of people in the community have comorbidity.

That means those people have a comorbidity of drug and alcohol and mental health issues. That does not of itself resolve the issues of those to whom the Drug and Alcohol Office is reaching out who may not have comorbidity. The Western Australian Network of Alcohol and other Drug Agencies and a number of organisations have made the observation that simply because we have this prevalence of comorbidity of drug and alcohol use with mental health does not mean that everyone who needs to be provided with a drug and alcohol service has a mental health problem. In my view, this will significantly impede the capacity of the government to provide drug and alcohol services to the broader community.

The reasons cited for merging the Drug and Alcohol Office with the Mental Health Commission include that it is a response to the Stokes review. It is not; the Stokes review does not call for the merger of these two entities. Another reason is to reduce the duplication of roles. The minister has said that the duplication is really in the back end of the organisations and not in the front end and the delivery of clinical services. It is not as though we will see large chunks of what Stokes called for, which is the joining of clinical services. The minister says that the efficiencies that will be gained through the process will be in the back end. We will need only one photocopier and one receptionist, one manager and one accounts department. It is important that the minister provides us with an understanding of exactly how many full-time equivalent positions will be lost from the

Drug and Alcohol Office and what will happen to that human resource. Will that human resource be pushed into clinical services or will it be considered as part of some sort of efficiency dividend and returned to the government, or will it be surrendered in the process? The government has not provided us with much justification of these issues.

The Premier as the Minister for Public Sector Management has carriage of this bill. I accept that this bill is essentially machinery-of-government legislation, so I understand that the Premier would not have addressed those issues in his second reading speech, although we would like to see some of those issues clarified.

Some of the concerns raised in the community go to two essential issues. One is the name of the new entity and the other is the issue that I mentioned earlier about comorbidity. It is clear from the contact that we have had with people in the sector that there is a good deal of anxiety about the fact that the new entity that will be formed after the Drug and Alcohol Office is merged with the Mental Health Commission will be named the rather creative title of the Mental Health Commission. There is no mention of alcohol and other drug services in the title of the new entity. This was confirmed by the Minister for Mental Health in her evidence to the estimates committee in the other place. I cannot for the life of me understand why the government would seek to completely subsume the entity of drug and alcohol services into the Mental Health Commission.

[Member's time extended.]

Mr R.H. COOK: All those drug and alcohol services will be subsumed into the Mental Health Commission. One of the things that the Mental Health Commission has made observations about and one of the things that Professor Stokes alluded to in his report is the lack of capacity of people to access services; people will find it difficult to identify and access the appropriate services. I cannot see a better example of that than an entity called the Mental Health Commission providing drug and alcohol services. People who have drug and alcohol issues that they want to have resolved and people with services that they wish to see delivered will go to the Mental Health Commission to receive those. If the government's aim in response to the Stokes review is to provide greater clarity about accessing these services, surely it would have done the bleeding obvious and incorporated "drug and alcohol service" in the title of the organisation. If, as I said before, and I suspect, part of this process is simply about growing the empire of the Minister for Mental Health, it makes sense that drug and alcohol services are not mentioned in the title of the legislation. This is because the government is more focused on growing the Mental Health Commission pot than on looking for improved services around alcohol and other drug use. I am informed by members of the sector who have raised what I think is a great point. They looked at similar organisations in other states: in New South Wales, the entity is called the Mental Health and Drug and Alcohol Office; in Victoria, it is called the Mental Health, Drugs and Regions Division; in the Australian Capital Territory, it is called the Mental Health, Justice Health and Alcohol and Drug Services; in Queensland, it is called the Mental Health Alcohol and Other Drugs Branch; and in South Australia, it is called the Mental Health and Substance Abuse Division. In terms of what is considered best practice, I think it is pretty clear that when these entities have been brought together, these organisations have been labelled clearly so people understand the mission of the combined department. Perth Inner City Youth Service contacted the opposition with concerns about the delivery of its services to young people, particularly young people starting to come into contact with drugs. PICYS is concerned that doing this will further marginalise a group that is already struggling to find these services. For instance, PICYS states —

> Alcohol and other drugs are a significant issue for the community, consumers, family members and other individuals with whom PICYS work and assists. The name of the government department responsible for AOD should reflect that responsibility in its title. Youth, Community, Sector members and family members need every opportunity to find the responsible department and services available. The Young People that PICYS engage with are amongst those most stigmatised, marginalised and discriminated against in the health sector according to the World Health Organisation, do not want to be seen as having a mental illness or their specific needs not being recognised.

Perth Inner City Youth Service is saying that it understands that many people who come in contact with these sorts of services may have comorbidity issues, but that is not the sum total of all the people who need drug and alcohol services. They do not all have comorbidity issues. To simply lump them all into the Mental Health Commission and subsume them completely under the title "Mental Health Commission" does no justice to the services that they provide and pays no respect to the people providing those services. It seems self-evident that one would take the opportunity to expand the title of the Mental Health Commission when it is being combined with an entity that is actually larger than it. It seems self-evident that one would seek to incorporate the names in the title of the combined entity. To take this larger department and jam it under the Mental Health Commission banner devalues a lot of the work being done in drug and alcohol services.

The Premier, in his second reading speech, essentially addressed the mechanical aspects of this, but this bill raises a range of important issues about how we couch policy on drug and alcohol services; how we structure or engineer the services that they deliver; how those services work with other departments in not only the mental health sector, but also police, corrective services and so forth; how those services are engineered and brought together so that they join up; and how that combined entity works with the sector to continue to deliver drug and alcohol services for not only those who have a comorbidity issue, but also those who are seeking drug and alcohol services who are not necessarily at the onset of or have a mental health condition. I want to understand why the government is so intransigent on this particular matter. Why has the government dug in its heels on the title of the new entity? Why has the government so strongly rejected the very reasonable and sensible response from the sector? The sector understands that the government wants it to work inside the Mental Health Commission, but believes because of the nature of the services that it delivers that those services should be recognised in the title of the combined entity. That is not an unreasonable position, and it is not an argument that the government has appropriately responded to.

The opposition will support this legislation because we understand that it is part of the ongoing process to reform mental health services, but we seek answers to these questions from the Premier in his reply to the second reading debate. We seek to further clarify these issues at the consideration in detail stage. I think the sector has been very reasonable in its approach to this. When the amalgamation of the two entities was first mooted, we acknowledge that it was widely accepted in the sector that this was the way things were going and they thought their aspirations to have drug and alcohol services recognised in the title would be readily accepted and reflected. It is interesting that the sector has since come back and said that the government will not be moved by these arguments, will not continue to work cooperatively with the sector and has rejected the suggestion that the name should encompass drug and alcohol services as well. I think that is disappointing and I cannot understand why the government has taken such an inflexible approach. I could understand it if the main concern was trying to leak resources from the drug and alcohol services sector into the main body of the Mental Health Commission. I could understand it if that was the government's approach, but I hope that it is not the approach. If it is not the government's approach, why is it so stubborn about this particular issue? I am unsure what the arguments are for collapsing or legislating out of existence a statutory authority that is widely accepted to be doing a good job in its area. I am unsure why the government has decided to take this particular course of action. But we understand that the government has taken this course of action and that it wants to see services improved. If that is the case, it is appropriate for the government to respond to the concerns and not simply wave them away saying this is its response to Stokes, because Stokes did not call for it. The government cannot simply say that it wants to see services joined up, because although there is a large sector with comorbidity issues, they do not account for all people to whom services should be delivered. Accepting that not everyone who needs drug and alcohol services has a mental health issue, for the life of me I cannot understand why the government has not included alcohol and other drug services in the title of the combined entity; it really escapes any logic or reason.

As I said, a number of members on this side wish to speak on this bill tonight, because obviously alcohol and drugs are very important issues in our community. Alcohol continues to wreak havoc upon families and people's lives. In particular, alcohol is taking an increasingly large part of our social and public services. We have to in some way rein in the influence of alcohol in our community. Occasionally we see a lot of hysteria around illicit drugs being sold on the street in an unsafe way. I acknowledge that illicit drugs are an issue, but if nothing else, we must come to terms, in this place and in the government, as public policy advocates, with the untold damage that legal drugs, in particular alcohol, are doing in our community.

MS L.L. BAKER (Maylands) [7.31 pm]: I am the lead speaker on the Alcohol and Drug Authority Amendment Bill 2014. I think I have the one-hour gig.

Mr C.J. Barnett: Perhaps we should go get a coffee or something.

Ms L.L. BAKER: I thank the Premier. I am sure he will be riveted to every word I say.

I want to start by focusing on an issue around alcohol that many of us have been dealing with, or will be dealing with in the very near future, in our electorates. It is something that I more or less fell into when members of my community started to contact my office to indicate their concern about the potential for a 1 200 square metre liquor outlet to be built on Guildford Road.

I ask the Acting Speaker for some protection.

The ACTING SPEAKER (Mr N.W. Morton): Member for Mandurah, if you wish to make a contribution, seek the call from the chair, please.

Ms L.L. BAKER: It is not nice when my own side is interrupting, is it?

Members of my community contacted me with their concerns when Coles put a proposal to the City of Bayswater to turn the old Cascades Tavern site into a liquor outlet. Those who know my electorate and Maylands will know about John K. Watts' old Cascades Tavern site, which is an iconic, although empty, block of land in the redeveloped Maylands. Many people have said it is an eyesore, and it is. It is an empty block of land with a cyclone fence surrounding it, which keeps getting graffitied and knocked over, and creates other sorts of problems. Nevertheless, when this proposal came up my community was very quick to come to me and say that it did not think that this was the best use of this iconic block in the middle of a newly invigorated Maylands. I tend to agree with my community. There are 16 liquor outlets within a one-kilometre radius of the proposed location of the new outlet. Even by the broadest definition of what is required by a market, I do not think that anyone can argue that 16 outlets do not provide any consumer of alcohol with sufficient choice, so that another 1 200 square metres of discount alcohol is necessary in the centre of Maylands.

The battle was on between the community and, initially, the development assessment panel, which looked at the site and gave it a big tick. As we all know, the development assessment panels operating in Western Australia have no regard for social amenity in our neighbourhoods. Any member of the community, confronted with that reality, has put their trust in a democratic system and elected councillors to the local government authority. The local council has said that it did not want the development. Notwithstanding what the community or its elected representatives say, the community in Maylands, as do communities in many other electorates, finds itself completely bypassed as Coles, one of the big duopoly, takes the application forward and bypasses the council, the elected representatives that we voted for. We do not matter. The matter goes to an unelected group of people who have their say based only on whether the square metreage is right, whether the walls comply, and whether the parking and traffic access are right. They do not have to live near these outlets. They have no direct interest in the issues of increasing antisocial behaviour, binge drinking, youth drinking, crime and a cascade of other problems that come from the abuse of alcohol. Members of the development assessment panel do not care about those things, because they are looking only at the development process. That is a direct assault on the wishes of the community. I understand the rationale for development assessment panels for the big projects, but the by-product is the level of development by the two major grocery retailers—Coles and Woolworths—as they battle each other to the bottom on alcohol prices.

The development assessment panel gave the tick to this development and it went to the Liquor Commission for a hearing, because a new liquor licence was needed to open this big 1 200 square metre barn in the middle of the electorate. The commission is bound by the Liquor Control Act. That act was amended recently, under the current Leader of the Opposition, opening up the concept of small bars, which have been a very productive addition to the social capital in our community. They have not been negative things; they tend to attract people to small and more intimate venues. They tend not to be cheap places to drink and they usually sell meals as well. They attract a group of people who are not the most vulnerable or abusive drinkers in our society. However, the amended Liquor Control Act gave equal weight to the objects in the act, which might sound deceptively simple and logical. Why should we not equally weigh the objects of the liquor act so that we have no capacity, when the Liquor Commission hears cases for the issuing of new licences, to give greater weight to social amenity, or whether the social impact will be great in a community, than to the commercial aspects of the proposal? If an applicant for a liquor licence can prove that it is in the commercial interest, because there are not enough liquor outlets, and not enough selection and choice in the area, or that market supply will be restricted, regardless of the destruction that might result from the issue of that licence, the commission is bound by the act, and this is not a good thing. It might have been a good thing when it was mooted, but it has certainly had an indirect impact that has been, I would say, abused by the big duopoly. My view is that Coles and Woolies have the wrong business case for this century. Only the other day at lunch I made that comment to a colleague who replied that, in fact, commercially they had the right business model because they are flogging cheap alcohol and there is a market for that. I disagree with every part of that refutation. I think they do have a completely unsound business model and that consumers in Australia are starting to recognise that and starting to empower various authorities to stop this spread.

The development assessment panel had ticked the big Liquorland. The Liquor Commission took six or seven months to make a decision after my community went to the commission and spoke at the hearing. It took six to seven months and we thought we really had no hope. But at the end of that time the commission rejected the application by Coles, so there was much partying and I must say a couple of bottles of champagne were opened to celebrate at that point! I am not sure where we bought them from, but we did celebrate with the community that all its hard work to show that the social impact of this liquor store was not acceptable had succeeded. Of course, Coles moved immediately to appeal this decision to the High Court, and I somewhat sadly had to say to my community that although I would have loved to have kept going, I did not have the money to go to the High Court and fight a case on this basis—it would not have been appropriate for me to do so. Therefore, we had to sit and wait for another six months. It was nearly a two-year journey and there begs another story about how

the hell the community is meant to fight these cases when it took two years to fight this one. My staff was heavily involved in helping to do the work, and it just would not be possible unless a person was very well resourced or had the capacity to set aside time to fight the fight. At the end of that time, the High Court upheld the decision and Coles was not permitted to go ahead with that Liquorland. We thought we had done a great job. We all went back to our respective homes and went to our respective bottle shops to buy a bottle of celebratory alcohol from the small businesses in Maylands.

Mr C.J. Barnett: Are you starting to think you are part of the problem?

Ms L.L. BAKER: I would like to think I am a moderate part of the solution!

I remember saying that there are 16 bottle shops in a one-kilometre radius in my electorate, and they are small businesses. I can tell members that they were greatly relieved by the outcome of the High Court challenge and were very thankful that my community had chosen to fight this off. Then, of course, not even a year later, the dust had not settled on the signs on the petitions when Dan Murphy reared its head on another site right next to the railway line and we started to fight again. That journey has been eight months in its progress. The council rejected the Woolworths plan immediately. I should explain that this is not a new liquor licence being asked for. There is a really grungy, dirty, smelly old tavern in the middle of Maylands right next to the railway line that everybody wants pushed over and a new tavern built. They want the social capital of the community to be added to by having a nice place to go with the family or to go for dinner and to have some social interaction. They do not want a 1 000 square metre takeaway cheap liquor outlet, and that is what has been proposed—with a little pimple on the bottom of it of about a 10-table tavern just to placate people. It is the most appalling abuse of Woolworths' commercial interests in this case. I should also say that there are about eight or nine agencies that deal specifically with the disadvantaged and the vulnerable within a kilometre of this proposed venue. One of them is 55 Central, whose sole business is the rehabilitation, support and accommodation for homeless people with alcohol problems. It is specifically concerned about this particular target group and it is 500 metres from this new venue being proposed. There are two dialysis hostels for Indigenous people who come from the Central Desert and the electorate of my colleague the member for Kimberley and from other places where there are not dialysis centres on location. As I say, they are within hundreds of metres of these proposed sites as well. There is a shopfront run by the Catholic Church that delivers emergency relief parcels—some 1 500 a week, I think—to vulnerable alcohol and drug-affected individuals and also to people with other forms of illness that make them homeless and vulnerable. I have just given examples of some of those eight or nine agencies that are within spitting distance of this new proposal.

So we are again fighting. This time it is an extension of a liquor licence. As I said, the City of Bayswater originally said no. The proponents then went to the development assessment panel, and once again, the development assessment panel said if modifications were made, it would be all fine. The panel gave the tick and so once again we are back waiting for the Liquor Commission so we can get the chance to say that it is not okay just to look at how much alcohol can be sold in these venues; it is not okay just to look at how much money can be made from discounting alcohol; it is not okay just to look at how many bottles can be pushed out the door; and it is not okay just to look at how much extra profit Coles or Woolies can put on their shareholders' bottom line. They have a social and moral responsibility and they are not fulfilling it—they are clearly not fulfilling it. Every time I open the paper I see yet another proposal with someone else fighting these two giants in either of these levels of the planning or approval processes. I again see communities struggling to, first of all, navigate the system, which is very complex and difficult. I just congratulated the member for South Perth outside this house an hour ago about the fact that he and several others went along with the Como community to fight against the Dan Murphy's application for Como. They actually won that at the development assessment level on a planning issue on traffic management. They were lucky they had that kind of issue; most of us do not understand the system. Planning is not an easy subject. To understand the ins and outs of planning laws and regulations, one needs to have some specialised legal or planning advice—and how is the community going to be able to afford to fund that? I think in the instance of South Perth and Como, Ashley Cranenburgh and others were managing to bankroll a lot of this themselves; they put a lot of money into fighting the campaign. They played the role that I have been playing in Maylands in some respect to help the community. They had an action group and the City of South Perth got behind them as well.

The journey for my community, and for many of our communities around destination liquor outlets, underlines a number of things that I want to bring to this debate. There is still contention over the link or the pathway between alcohol outlet density and impacts on mental health, and I want to just talk about some of the pathways I know of from the research that has been provided. I am going to loosely refer to piece of research by Pereira, Wood, Foster and Haggar on potential pathways between alcohol outlet density and mental health. I will supply this to Hansard so it can be included. The first is availability, the second is affordability and the third is advertising. In the debate around alcohol, it is these AAAs—which we have not lost so far; we have hung onto

these, unfortunately—that we talk about when we talk about the link between increased alcohol outlet density and mental health. It has been hypothesised in research that increased alcohol outlet density can impact on alcohol-related harm. Increasing the number of alcohol outlets reduces the real cost of alcohol, incorporating the convenience of making a purchase, along with a lower monetary price, thus increasing consumption and related problems. That is from the research that I referred to earlier. Similarly, it is suggested that alcohol availability, particularly outlet density, increases market competition and makes alcohol discounts more prevalent. For those who are already predisposed or vulnerable to alcohol abuse, the availability of cheap local alcohol in vast quantities is a predicator of abuse.

When I was studying psychology, one of the things we were taught was that habits that are acquired under thin schedules of reinforcement are the hardest to extinguish. In plain English, that means that if we have a problem with something, the further away we put the source of that something, the better it is. That is not really ground-breaking stuff, but it was at the time a premise of psychological theory. Therefore, this issue of affordability is that when cheap alcohol is available locally at this type of level, it adds to the vulnerability and negative impact on those who are predisposed to harm from alcohol consumption.

The "amenity effect" is a term that refers to the presence of alcohol outlets influencing the quality and characteristics of the surroundings and the local community. In Australia, Donnelly et al found that people who live in close proximity to a liquor outlet are more likely to report social problems such as drunkenness, property damage, visible public intoxication, violence and street disturbances. In turn, this can adversely affect mental health in a number of ways by the evaluation of environmental stresses and the impact on feelings of safety and anxiety and the sense of community.

Another pathway that has been cited in this research is visual and normative cues. That refers to the sorts of cues that come from the presence of alcohol outlets within a neighbourhood. The quantity of this kind of cue is influenced in part by density. One of those cues is the social modelling of drinking behaviours. If we see people drinking, and we see the advertising and the promotions, it normalises alcohol consumption, and it reinforces that alcohol is an option for coping with stress or difficult times. That in turn contributes to the increased use of alcohol and to health-related harms. There is a lot more in these references, which I invite members to look at, but that will do for the moment.

Alcohol density is a very grave and more frequently occurring problem for us to deal with in our communities. I would personally much rather see small retail outlets in my community that sell a range of products but do not trade off the big advertising banners that Dan Murphy's and Liquorland use of "We'll beat every price" or "We have the lowest price in the land." That type of advertising is quite appalling in light of the problems caused by alcohol.

I want to move now to alcohol-related harm, because in this bill we are looking at adding alcohol and drugs to the title of this very important merged entity. Under this change, the Mental Health Commission will also incorporate drugs and alcohol. I think it would be advisable to tell the community what this new entity will do. For those of us who know that mental health is often closely associated with alcohol abuse, and often with illicit drug use, we understand how the Mental Health Commission could incorporate alcohol and drugs. But, quite frankly, I do not think that an Indigenous person who was suffering from the overuse of alcohol, or a drug condition, would feel very comfortable—I beg to be told otherwise—about being labelled as part of the mental health system. I do not think that is a perception that is necessarily appropriate or correct. We should think carefully about putting that perception onto people who do not label themselves as having a mental health problem; and, indeed, it would be very difficult for some people in their communities to be labelled as that. Whether we like it or not, alcohol abuse is very prevalent in some communities, and its acceptance is a problem. I cannot argue against that. However, to label that alongside mental illness may not be the best way for the people concerned to address this issue.

The other point I would make is that that alcohol is causally linked to more than 60 different medical conditions. A report that was prepared for the Australian Government's Preventive Health Taskforce, titled "Australia: The Healthiest Country By 2020 — Technical Report No 3: Preventing alcohol-related harm in Australia", states that in Australia, alcohol is linked to 3 430 deaths a year and 85 435 disability-adjusted life years. The report states at page 11 that in the 10 years between 1992 and 2001, more than 31 000 Australians died from alcohol-attributable injury and disease, and a greater number died from acute rather than chronic conditions. The specific causes of those 3 430 deaths are listed as alcohol abuse; suicides and self-inflicted injuries; road traffic accidents—we know that a hell of a lot of people are involved in traffic accidents as a result of alcohol abuse—oesophagus cancer; breast cancer; and a cluster of other illnesses. The most common cause of death due to intoxication was road crash injury, and among the chronic conditions alcohol-related liver cirrhosis accounted for the majority of deaths. Deaths from acute causes are more common among young people, particularly those aged 15 to 29 years, while deaths from alcohol-attributable chronic diseases are more common among people over 45 years of age.

More males than females die from acute and chronic alcohol-attributable conditions. I am reading through these points, because these are not mental illnesses; these are other health conditions. That goes to the point that, in my view, it would be more acceptable to call this new merged agency what it is—if it quacks like a duck, it is a duck, so call it what it is. It is mental illness, drugs and alcohol. In Australia between 1993 and 2001, over half a million hospitalisations were caused by risky and high-risk drinking. The most numerous conditions among these hospitalisations were for alcohol dependency, injuries caused by assault, road crash injuries and attempted suicide. As many as 10 000 hospitalisations were attributed to alcoholic overdose from very high blood alcohol levels. This is quite often the binge drinking that we are seeing more and more in adolescent and young people.

In relation to the rate of risky drinking in Australia among young people, alcohol-related harm is substantial for both adolescents and young adults. Drinking contributes to the three leading causes of death among adolescents—unintentional injuries, homicide and suicide—along with risk-taking behaviour, unsafe sex choices, sexual coercion and alcohol overdose. Regular drinking in adolescence is an important risk factor in the development of dependent and risky patterns of use in young adulthood. We know that childhood and adolescence are critical times for brain development. How many times has this Parliament been told that the brain is still developing until 20 years of age and that any alcohol that is consumed while people are young will slow down or impact on the rate of their brain development? Like adolescents, young adults continue to be greater risk-takers than older adults, but their decision-making skills are undeveloped. That is reflected in the high levels of injuries sustained by this age group.

All that goes to the issue that I want to raise about the use of alcohol by young people. Again, this is a target group of people who will not necessarily be all that pleased about being labelled as mentally ill or having mental health issues. These are young people who may be subject to a whole range of hormonal and other stresses, but they may not relate to mental illness. These young people may very much reject that diagnosis. With a service such as this new service that will be merged—with no full-time equivalent losses, we hear, and, hopefully, with greater strengthening of some of the clinical aspects of the service—it is really important that at all times the clients of the services understand where to go and that they feel included in the service and not estranged by the label of the service.

Over the last couple of days, I am sure that members would have heard the news that on 8 September the National Drug and Alcohol Research Centre at the University of New South Wales released the results of a new study into pathways to drink in children. This study was about parents being the largest suppliers of alcohol to children under 18. Teens are three times more likely to drink full serves if parents supply them. The issue of the secondary supply of alcohol is one that has been brought to this house by the member for Collie–Preston, the shadow Minister for Racing and Gaming. I am aware that the Minister for Sport and Recreation; Racing and Gaming also has a review of the Liquor Act under his belt at the moment. It is extremely important that the issue of secondary supply of alcohol by parents is raised in that review. Labor introduced a bill in June 2013 to protect children from the impacts of alcohol. The shadow Minister for Racing and Gaming, Mick Murray, put that bill before the house and said that Labor introduced the Liquor Control Amendment Bill to ensure that a person cannot supply liquor to a juvenile on unlicensed premises unless the person is that juvenile's parent or guardian or has the parent or guardian's permission to supply the liquor. This is one really important step that simply has to happen. Three or four other states of Australia already have secondary supply laws, including New South Wales, Victoria, Tasmania and maybe Queensland—I cannot quite remember the fourth state. This legislation is already in place. It relates to regulating the supply of alcohol so that parents who do not let their kids drink alcohol can be confident that when their kids go to a function or a party at someone's house, they will not have alcohol supplied to them, and the parent or guardian who is supervising the children at that party is responsible for making sure that that does not happen. I am not saying that that would be easy to enforce, but we have to look at this; it is essential.

Going back to the research of the National Drug and Alcohol Research Centre, I want to put on the record some more of its findings. It found that teenagers whose parents supply them with alcohol in early adolescence are three times more likely to be drinking full serves of alcohol at age 16 than are children in families whose parents do not supply them with alcohol. When people are criticising those who ask for secondary supply legislation and the like, many of them say, "But the Europeans do this. They nurture their children and let them have a little sip of alcohol at dinner, and it's all fine. The culture is different; it's all fine. This is what we should be doing." That is not the truth at all, and if people think it is, they are very much out of step with reality. Binge drinking in Europe is in massive proportions. Evidence of that was delivered to us recently by the professor who runs the alcohol research centre in England—I cannot quite remember his name now; I am sorry about that. He was very clear on this issue. This is not a model to be followed; it simply does not work in this time. It might have worked in another time, but it does not work in this time, with the many different pressures that parents and children

face. People should put out of their minds the fact that allowing children to have a sip of alcohol, nurturing them and showing them how to drink effectively will help, because it is not going to happen these days.

In the largest study of its kind, researchers at the National Drug and Alcohol Research Centre followed nearly 2 000 parent–child pairs over four years in a bid to provide guidance to parents on how to moderate children's drinking. At age 12 and 13 years, close to one in six children in the study reported being given alcohol by their parents. By 15 and 16, 15 per cent were drinking full serves, compared with only 1.5 per cent of the younger children. The researchers found that the early parental supply of alcohol through school years 7 to 9 was the single biggest predictor of drinking in year 10. It was more influential than family circumstances and issues, more influential than individual psychological risk and more influential than even peers. They are the most outstanding results, and are significant and quite surprising, really. We know that adolescent drinking is associated with a wide range of later harms in early adulthood, including injuries, sexually transmitted diseases, alcohol dependence and changes in the brain function. All these things are directly linked to the supply of alcohol too early and to unformed brains.

I will say a few words in support of the need to make quite clear the message that when the government merges this service, the new entity will not be about just treating mental illness. Members would know that the Western Australian Network of Alcohol and other Drug Agencies is a fantastic organisation. It is the peak body in the drug and alcohol area in the not-for-profit sector. It has been operating for many, many years. At last count, I think it represented more than 90 agencies in the drug and alcohol not-for-profit area. It speaks on behalf of the drug and alcohol not-for-profit sector. It is the peak body for the network. It has raised the issue that the purpose of the legislation makes reference to mental health issues rather than mental health illness. The words "mental illness" will be replaced throughout the act by "mental health issues" unless specific context requires otherwise. I will put this point on record because the Western Australian Network of Alcohol and other Drug Agencies is a credible organisation that has worked closely with this government to get things this far. WANADA is hopeful that this new entity would be productive and offer a significantly increased service level for this very important area. WANADA's concern around this change in the title from mental illness relates to the definition of the Mental Health Commission's 2020 strategic policy as a clinically diagnosed mental disorder. The previous speaker and I covered in some detail that mental health issues are broader than diagnosed conditions and are far more prevalent than a diagnosed mental illness. The alcohol and drug sector primarily provide a service to people with co-occurring alcohol, drug and mental health issues and they feel it is important that the act supports both sectors, and that will demonstrate an inclusiveness of these issues by recognising that we are not ignoring the incredible importance of the emergence of drug and alcohol as problematic in our community. We know that mental illness is a huge issue, but the abuse of drugs and alcohol is just as great an issue. We do not necessarily have 100 per cent comorbidity; it is 30 to 50 per cent. That leaves 50 per cent of patients who do not suffer from comorbidities, and if those 50 per cent of people do not identify with the service, they will not go there, which will be a great loss. Given the public profile of alcohol and other drug issues, WANADA feels that the department should be clearly recognised by the community as being responsible for both mental health, alcohol and other drugs. Previous speakers referred to some of the titles used by departments in other states, such as the Mental Health and Drug and Alcohol Office and the Mental Health and Substance Abuse Division. It sounds like a fair option, and I cannot imagine what rationale the government has for not recognising the need to be inclusive in the title of this entity. The commission needs to be given every opportunity to succeed. In many respects, by not making the title inclusive of these issues and by changing the definition to "mental health issue", which muddies that definition somewhat, the government stands to alienate some people and to tie one hand behind the back of the Mental Health Commissioner, who is an outstanding individual who I am sure will do a very good job at running the new commission. However, he will do it with one hand tied behind his back unless a more inclusive title is given to this new body.

Perth Inner City Youth Service has added its considerable experience to this debate. The Premier will have received some comments from PICYS on the new Mental Health Commission and the naming of this bill. I remember when PICYS started back in the time when Alister Norwood kicked off Jeanswest.

Mr R.H. Cook interjected.

Ms L.L. BAKER: The member is speaking to a girl who used to work for Jeanswest, so I remember it well. I remember when the youth service started up there—we will not go into Jeanswest, which is another story! PICYS has been delivering fantastic support to youth in the state for over 30 years now. It is very concerned that if this body loses the drug and alcohol component in its title, it will lose some of its efficacy as well. PICYS thinks that the new amalgamated name suggests that drugs and alcohol are not significant issues in the community among consumers, family members and other individuals with whom PICYS works and assists. The name of the government department responsible for alcohol and drugs should reflect this responsibility in the title. It seems to me far too logical. Why would the government want to call something what it is! It is about

mental health, alcohol and drugs. It is not one or two of those things, it is all three, and not to call it what it is is an opportunity lost in connecting with clients—not to mention the loss of inclusivity that that would bring.

I think that I have covered most of the issues I wanted to put on record about this bill. I know that I am finishing a little early, but other people wish to speak on this. The Mental Health Commission has a daunting task ahead of it. The issue of drug dependence, the illicit use of drugs and the overuse and abuse of alcohol in our community are emerging as key social issues in everyone's electorates, neighbourhoods and communities. To understand whether it is related to alcohol outlet densities with the big-name outlets, or with binge drinking and preloading that we hear so much about, we need only listen to the Commissioner of Police or the President of the Children's Court, His Honour Judge Denis Reynolds. They give a very good description of the scourges of alcohol abuse and illicit drug use in our community. They do not necessarily talk about mental illness when they talk about drugs and alcohol, so there is no natural fit between the negative impacts of that and drugs and alcohol abuse. We know there are comorbidity links, but not in every case—it is the reality in 30 to 50 per cent of cases. That is what people in the sector are saying, and I listen to them because they are on the front line delivering the service. I know that the minister has her heart in the right place, bringing services together and wanting to keep strength in service delivery and getting the right services framework for the community; however, I do not get why she would miss the opportunity of calling it like it is. I do not understand why the minister would want to tie one hand behind the back of the new commissioner by calling this new body something that it is not. It is not just the Mental Health Commission; this body will deal with the impact of alcohol abuse as well as illicit drugs and mental illness. Let us name it. We know that if it is not named it does not count. I am very much aware from a feminist perspective that the history of not naming something correctly is well recorded. If we do not count women's participation or gender participation and instances of where that is missing, and if we do not identify the gaps, they are ignored. I fear this will be the case if we do not count or recognise the role that this new agency will play in fighting drug and alcohol dependence and we will miss a very big opportunity.

With those few comments, I understand that my colleague is drafting some amendments. The opposition supports the bill. Members may ask, "What's in a name? It's just a title." A title is everything. It is our front door. When people pick up a piece of paper, they read a story and it is not just a drug and alcohol service or just a mental illness service. They are the points that are fundamental to this argument and I really hope that the minister listens and is more flexible in her outlook in this case.

DR A.D. BUTI (Armadale) [8.19 pm]: I also rise to contribute to the debate on the Alcohol and Drug Authority Amendment Bill 2014. When we discussed the Mental Health Bill some time ago, the government mentioned it would introduce legislation to bring the Drug and Alcohol Office within the purview and jurisdiction of the Mental Health Commission. At first, I thought this was not an appropriate move because of the problem that it would stigmatise people who had a mental illness with also having a substance abuse issue. But then part of me said that was also a natural fit because there is a strong link between mental illness and drug and alcohol abuse. However, as the member for Maylands had stated—I do not know the actual figure—around 50 per cent of mental illness has a comorbidity issue, but the other 50 per cent has not, so there are pros and cons to what the government is seeking to do here.

I think the legislation has many good parts to it. The minister responsible for the Mental Health Bill 2013 had put a lot of time and effort into seeking to get that legislation right, and I think considerable effort has been made with the bill we are discussing. It is interesting to note when one looks at the bill before us—we will be dealing with this more during the consideration in detail stage of the bill—that, from my reading of the bill, the Mental Health Commissioner will perform the role of the CEO under division 2 of the bill and he or she will have responsibility for the organisation. The commissioner's functions are quite involved and quite extensive, so a lot of demand will be placed on the Mental Health Commissioner by bringing together the Alcohol and Drug Authority and the Mental Health Commission.

All those duties and functions are contained in clause 11. I notice also with interest the establishment of the board under division 3. Clause 14(1) of the bill states —

> The Minister must establish the Alcohol and Other Drugs Advisory Board to provide advice to the CEO about matters relevant to the performance of functions under section 11.

Clause 14(3) states —

> The Board must consist of the people that the Minister thinks fit to appoint.

That is not an unreasonable provision, but I would have preferred some further prescription of who should be on the board. For instance, if there is a board, I do not know how many members it has. Does it state that in the bill? I am not sure, but if there are eight members on the board—as I said, I am not sure of the number—one member should be a psychologist or a mental health specialist and maybe one should be a lawyer for legal issues. I do not

want to prescribe every single position on the board, but at least some of the positions should have to meet a certain criteria. That prescription is not within the bill before us, and I do worry about that because, of course, the minister will have complete discretion in determining who the board should comprise; however, I think the minister's job would be made easier if the bill were prescriptive about who should be on the board. Many government boards that are functioning today have requirements that certain professions or certain types of qualifications need to be represented on those boards. That might be something for us to mull over and discuss during the consideration in detail stage.

The member for Maylands raised an interesting point about the name of this authority. In the Premier's second reading speech, he states —

> This bill is required to amalgamate the functions of the Mental Health Commission with the Western Australian Alcohol and Drug Authority.

The Premier mentions Bryant Stokes and, of course, the Stokes report, and states —

> … "Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia". The Stokes report outlined that access to services is difficult for patients with combined mental illness and drug and alcohol conditions.

I think that is probably one of the driving forces behind this legislation—namely, the recognition by Professor Stokes of the problem of accessing services for people who have a comorbidity issue with mental illness and alcohol and drug problems. I think that is a laudable purpose behind this legislation. I am still not 100 per cent sure, given that I have not had a chance to thoroughly examine the bill, but I presume that the name of the organisation will be the Mental Health Commission, which it presently is, but will there be a department or an office within that called the Drug and Alcohol Office? Maybe the Premier can elaborate on that at a later stage; I am unclear. In some respects it might allay the fears that the member for Maylands discussed. It probably will not, but at least it will go some way if a name is identified under the umbrella of the Mental Health Commission.

I note that in New South Wales there is the Mental Health and Drug and Alcohol Office. Its website states —

> The Mental Health and Drug and Alcohol Office … is responsible for developing, managing and coordinating NSW Ministry of Health policy, strategy and program funding relating to mental health and the prevention and management of alcohol and drug related harm. The office also supports the maintenance of the mental health legislative framework.

It further states —

> The work of MHDAO is delivered mainly through the mental health program and the drug & alcohol program, in partnership with Local Health Districts, Justice and Forensic Mental Health, Sydney Children's Hospital Network, Non Government Organisations, research institutions and other partner departments.
>
> The Mental Health and Drug & Alcohol Office … was formed in 2006 by the integration of the Centre for Mental Health, the Centre for Drug and Alcohol, the Office of Drug and Alcohol Policy, and Community Drug Strategies. The establishment of the Office is a response to the increased policy and funding priority given to these areas by the State Government and nationally under the Council of Australian Governments (COAG).

That, to me, seems to be what this legislation to some degree is seeking to achieve. I hope it is, because from what I have read about New South Wales that seems to be a very logical and sensible development whereby there is a recognition that in many cases there is a link between mental illness and substance abuse, whether it is alcohol or other drugs, but also there may not necessarily be that comorbidity issue, given that people can have mental illness issues without having an alcohol problem. Maybe that would have been a better way to go. At least having within the Mental Health Commission an office that is called the Drug and Alcohol Office would go some way to alleviating some of the concerns about the name.

Mr C.J. Barnett: There will be a section within the department that specialises in alcohol and drug areas—specialist programs—and there will also be an alcohol and drug advisory board.

Dr A.D. BUTI: I think that makes sense, but will it be within the Mental Health Commission?

Mr C.J. Barnett: It will be within the overall commission, yes.

Dr A.D. BUTI: I do not have a major issue with that. I think that makes sense, personally, but I think it is important to ensure that that is relayed in the various marketing tools and so forth so that people understand that. Some work will need to be undertaken by the Mental Health Commissioner who, of course, is a senior public

servant of many years standing, to ensure that he educates the public to understand that although there is often a link between mental health and substance abuse, they are not always the same thing.

I will relay a story based on our habit of often making a predetermined assessment or assumption. Yesterday, I was at the train station at Perth at about nine o'clock to catch a train back to Armadale and there was a young woman sitting down on one of the benches dressed in a suit, presumably ready to go to work, and I was about two or three seats away. Another woman came to sit down who, it would appear, had been sleeping rough. She was probably homeless because she asked for some money. I only had a little bit in my pocket—a couple of dollars, actually—so that was all I was able to be give her, but I noticed the other girl actually went through her purse and gave her what she had.

The woman, I presumed, was homeless, and I started talking to the young woman who had given her money. I said that it is really sad that people feel the need to beg and that I had seen an increase in the number of homeless people. She said that she had once been homeless, but that it had not been related to drugs. My immediate thought about the homeless woman was that it was probably related to drugs; maybe I should not have made that assumption. We probably make that assumption about people with mental illness when we should not. But the Alcohol and Drug Authority Amendment Bill 2014, which seeks to bring the Drug and Alcohol Office into the Mental Health Commission, is not extraordinary. As I said, those agencies have been brought together in New South Wales, and that is also the case in other jurisdictions. Much research has shown a link between mental health and the abuse of alcohol or other substances.

The member for Maylands mentioned the issue of alcohol in our society, and there is no doubt that it is a major problem. A report was handed down, I think, yesterday by some national body—the name of which escapes me—and Professor Hickey, who advocates an increase in the legal drinking age; I think he probably said to 21 years of age. I do not know whether he did say 21, but I imagine he did. He agreed that that would be difficult for politicians. I am sure the Minister for Racing and Gaming understands the difficult public policy issue of putting bans on people's ability to consume alcohol, and it is difficult for politicians to deal with. I have to say that I think there is a movement in society for that change, and Professor Hickey stated that the public is ahead of politicians on this matter. I have not seen the study so I do not know its veracity or who was surveyed or studied, but the public is warming to the idea of increasing the legal drinking age to 21. Of course, my immediate question on that is whether that will mean we will have more under-age drinking. Maybe we will, but I think the imposition of a legal drinking age reduces to some degree the consumption of alcohol by 18 and 19-year-olds.

Professor Hickey stated that it is important to delay the consumption of alcohol for as long as possible, because, as we know, the brain is still developing. At the age of 18 or 19, the brain is formed in such a way that risk-taking is more inclined to happened, and if that happens with alcohol in someone's system, it is very dangerous. It is unlikely that we will see the legal drinking age increased to 21 years during our parliamentary careers, but I hope that is not the case. It will depend upon how long we all serve! I do not think it will happen in the term of this Parliament. As Sir Humphrey Appleby from *Yes Minister* would say, "It's a very courageous decision, minister!" I think it would be a very courageous decision for this government or opposition to come out with a policy that the legal drinking age should be increased to 21 years, but maybe we would be surprised at the support that it may receive. We will see who goes first on that one!

Another issue that I think really needs to be looked at is alcohol advertising. Once upon a time in the not-so-distant past, the thought of banning tobacco advertising was laughed at; it was seen as being too difficult. I remember that there was a prohibition on the advertising of tobacco products, but an exemption was made for sporting events such as the Formula One et cetera, but I think even that has now been banned as I am sure that the Australian Grand Prix does not have tobacco advertising anymore. So, it is possible, but the battle to prohibit tobacco advertising was a long process. I think it is important that we start that process now for alcohol advertising. I do not think it is such a courageous decision. A lot of pressure would be applied by the various alcohol companies, but I think that process and dialogue should commence. It really annoys me that when I watch an Australian Football League game, there are three types of advertisements—alcohol, gambling or fast-food ads; those really healthy ads! I think the Premier might have mentioned something about this a while ago during the last Parliament about —

Mr R.H. Cook: It was about putting live odds on during the game.

Dr A.D. BUTI: I really detest the gambling ads played during football games. I think it has been changed now, but a betting company representative used to be on the ground giving the odds for the game, and it made viewers think they were actually an expert reporter. The alcohol ads are brilliant. No doubt those beer ads are fantastic. I am not a massive drinker, but when I see one of those ads, I want a stubby!

Mr C.J. Barnett: I always enjoy the one about the guys punching above their weight—I identified with that!

Dr A.D. BUTI: Yes, that is right!

Mr C.J. Barnett: So does the Acting Speaker!

The ACTING SPEAKER (Mr I.M. Britza): I will disregard that comment!

Dr A.D. BUTI: I think one of the clever ones is when they go away on holiday and the friends happen to be next door, and then the other one is next door. They are very sexist ads as well.

The Minister for Sport and Recreation has a great interest in the health of our community, but he is also responsible for the control of alcohol in our society. He is not responsible for the amount that people drink, but he does have responsibility for setting the parameters. I think that his job as Minister for Sport and Recreation has a public health component to it, and he should seriously look at the degree of alcohol advertising on television—full stop—but particularly in regards to sporting events. I understand the pressures and the sponsorship involved, but the same arguments were made by tobacco companies. Tobacco companies would sponsor sporting events to a phenomenal amount, and people would ask what would happen once we did not have the tobacco sponsorship; they would say that there would not be any prize money and events would not be put on. But of course that did not happen because other market forces came into play and people who were prepared to sponsor premium events could always be found.

[Member's time extended.]

Dr A.D. BUTI: It is important that legislative frameworks are set up to ensure that the public policy direction of governments is administered in a manner seen to be most appropriate, and this government thinks we should be conflating the alcohol and drug authority with the Mental Health Commission, for which there is precedent in other jurisdictions. The Premier has stated, though, that there will be an authority within the Mental Health Commission that will deal with drugs and alcohol, which I think is very wise, but maybe it needs to be labelled in a better fashion. Mental health illness is a major problem in our society that seems to be on the increase, partly due to factors not related to drugs and alcohol, but there is no doubt about the correlation between the many people who suffer from mental illness and drugs and alcohol. I am sure the Mental Health Commissioner will seek to encourage governments to implement policies that seek to reduce the possibility of people suffering a mental illness as a result of alcohol and drug abuse.

We must also remember that while in some cases substance abuse may cause a mental health problem, it is also incredibly dangerous for someone who already has a mental health problem to engage in substance abuse. A mental health problem or condition may not be a result of substance abuse, but someone with a mental health condition could aggravate, and most likely will aggravate, their mental health condition by consuming alcohol or engaging in substance abuse. That is why it is important to look at this as an overarching issue involving both mental health and drug and alcohol abuse.

I refer to the New South Wales Mental Health and Drug and Alcohol Office. I do not know whether the Mental Health Commission has a charter, but the charter for mental health care in New South Wales is interesting. It states —

> Every person in NSW has the right to mental health services that:
>
> 1. Respect human rights.
> 2. Are compassionate and sensitive to the needs of the individuals they serve.
> 3. Foster positive attitudes to mental health in the larger community.
> 4. Promote positive mental health.
> 5. Encourage true consumer involvement at all levels of service delivery and policy development.
> 6. Provide effective treatment and care across the lifespan.
> 7. Are widely accessible to people with mental health needs.
> 8. Provide care in the least restrictive environment, consistent with treatment requirements.
> 9. Provide effective and comprehensive prevention programs across the lifespan.
> 10. Promote 'living well' with mental illness.
> 11. Address quality of life issues such as accommodation, education, work and income, leisure and sport, home and family and other relationships.
> 12. Use language that reduces stigma, discrimination, or negativity for those affected and their families.
> 13. Respect and are responsive to the diversity in lifestyle, sexuality and sexual preference.

14. Are culturally sensitive and appropriate to the needs of the individuals they serve.

15. Encourage and support self-help.

None of the points in the charter for mental health care in New South Wales specifically mentions drug or alcohol abuse, but no doubt they are included in the charter when it refers to promoting living well with mental illness, and addressing quality of life issues such as leisure, sport, work and income. I would prefer it if it specifically mentioned the issue of drug and alcohol abuse, but I think it is implicitly included through the references to environment and living well.

This government, like all governments, has a major challenge with mental illness and drug and alcohol abuse in our community. It would appear that alcohol and drug abuse is increasing, especially, unfortunately, among younger people. Anyone who doubts that has only to visit Northbridge on a weekend. The Acting Speaker (Mr I.M. Britza) would recognise that, because as part of a committee inquiry we went to the Perth lockup one night and saw that nearly everyone in there was either drunk or on some other substance. There is a strong and categorical correlation between criminal activity, mental illness and alcohol and drug issues. We do not even have to go to Northbridge; we can just get on a train at night to see people who are suffering from a mental health problem and/or substance abuse. Unfortunately, at many parties, even ones run by parents, children engage in substance abuse. All of us in this Parliament have a responsibility. The government has an even greater responsibility because it sets priorities and determines budgetary allocation and public policy. Hopefully, this bill will assist the work of the Mental Health Commission with mental health problems and drug and substance abuse issues.

MR D.A. TEMPLEMAN (Mandurah) [8.44 pm]: I rise to make a contribution to this evening's debate on the Alcohol and Drug Authority Amendment Bill 2014. I want to highlight a few important issues that are associated with my electorate and my region. Given that this bill essentially collapses one entity and creates a new one, it is also timely to reflect on the issue of drug and alcohol abuse as it impacts on communities generally and, in my case, the communities in Mandurah and the Peel region.

Unfortunately, an increasing number of people are abusing alcohol and drugs in the region that I represent. The impact of that behaviour is reflected in a range of statistics. Some of these statistics concern domestic violence. The Peel, unfortunately, has a very concerning reputation with an increasing prevalence of family and domestic family violence. No doubt alcohol and drug abuse and misuse continue to be some of the key contributors to that appalling statistic. When we reflect on that, we begin to also recognise a range of other issues that impact on a community that is now over 100 000 people strong and that in 20 years will be the second-largest region in Western Australia. When we couple that with, until recently, some very worrying crime statistics, the issue of what we do as a community in both the region in which I live and what we do policy-wise in government and in Parliament is very important. The statistics for domestic violence in the Peel remain a great concern, yet we still do not have a comprehensive strategy to tackle this scourge. To tackle it, of course, we have to take a multidisciplinary approach that addresses alcohol and drug abuse, education, mental health and poverty. That cross-section of issues needs to be responded to. Integral to that is the provision of services. I am glad that the Minister for Regional Development is in the chamber because by his own admission the Peel and the south west have been the poorer cousins to other regions in receiving royalties for regions funding. I hope that when the regional blueprints come before the minister, he will question the programs proposed to be funded from royalties for regions. In the case of drug and alcohol abuse, there are some key areas in the Peel that I think royalties for regions is well placed to fund. The first is an extension of programs and services associated with domestic and family violence.

One women's refuge in Mandurah services the Peel region, which has been in place for a few decades, and it provides other services in addition to accommodation. But we also need programs aimed at addressing the perpetrators. On Friday, I met with Leanne Carter, who is based in Pinjarra. I think Leanne has an exciting proposal that she believes will assist us with a community response to the family and domestic violence that is a scourge in our community at this time. Leanne's program focuses on providing hostel-type accommodation for the perpetrators of domestic violence, so that they are the ones removed from the family situation and have services provided to them. In most cases, the female and the children are not required to escape and can remain in the home, and it is the perpetrator who is provided with services to try to address some of the issues that lead him to inflict violence on his family. I think that sort of program is badly needed in the region as well as, obviously, the ongoing funding and resourcing of the women's refuge and the dramatically important need for counselling services for children who are witnesses of and, indeed, at times, victims of family and domestic violence. I hope that when the blueprints come before the minister, he will ask questions of the Peel Development Commission about what it is proposing to do to address this social scourge of family and domestic violence.

Another associated issue that was highlighted by a couple of speakers, including, of course, the members for Armadale and Maylands, is the planning processes. The member for Maylands highlighted this very, very well in her contribution tonight. I want to highlight one example of a planning process that went through the joint development assessment panel for a piece of land on the corner of Lakes Road and Minilya Parkway in Greenfields. This plot of land is situated between two schools: the Foundation Christian College and the nearby Riverside Primary School. The Foundation Christian College boundary is fewer than 50 metres from the plot of land; it is across the road. Riverside Primary School's oval is 50 metres on the other side of the plot of land. In this stretch of Lakes Road all the land uses approved by council and the Western Australian Planning Commission over time have been medical uses. Our major hospital, Peel Health Campus, is just to the south and everything along Minilya Parkway is medical uses. There are doctors' surgeries, allied health professionals and the government's community health facility, which provides citizens with a range of services. All of them are medical uses, yet bookended within this precinct is a proposal, now approved by the JDAP process, for a McDonald's restaurant, a liquor store, and a 24-hour service station. They are all in a precinct that backs on to surrounding homes and is wedged between two schools. I appeared in the JDAP process. I went along on behalf of the community and a number of community members went as well. We were consistently told that our arguments based on social issues and concerns about locating such land uses within a precinct that was not of the same land use were not within the scope of the planning process. Therefore, the JDAP process discounted, disregarded and effectively rejected the concerns of the community, the school communities and many, many nearby residents. That process was very disempowering for hundreds of people in that location. Sadly, in this case, the proponent gets a second bite of the cherry if the council rejects the proposal—as it did. The proponent opted for a JDAP process after that and then, of course, the JDAP process saw the community ultimately overridden. No-one was actually opposed to those land uses—people have a right to go to liquor stores in appropriate places, 24-hour service stations and McDonald's 24-hour restaurants. The argument we raised was that those land uses were not appropriate for that locality. They were appropriate for another locality just further south on the corner of Pinjarra and Lakes Roads, and, indeed, in other parts of Mandurah. This is the only place in Mandurah where such uses—24-hour service stations, fast-food restaurants and liquor outlets—are not located within shopping centre precincts. For the people of Greenfields this is not the case; for some reason they were treated differently, and when they spoke out about it, they felt disempowered and let down by the process.

The social context is an important consideration when we talk about drugs and alcohol and the availability of alcohol. As many other speakers mentioned tonight, I think there is what seems to be an avalanche of liquor outlet applications. I know that a stringent process is undertaken by the Liquor Commission of Western Australia, but, in the example I mentioned, those people are likely to have land uses imposed on them that they definitely do not want. They understand why it is not an appropriate place for such land uses and that the pattern of development that has been allowed for such land uses has been very clearly designated by the City of Mandurah. In other parts of the city, such as in Falcon, those sorts of land uses are all within a shopping centre or a shopping precinct. In Halls Head, it is exactly the same. In Silver Sands, it is exactly the same. Why is it that the people of Greenfields are the exception? That is the problem.

Mr C.J. Barnett: Is Silver Sands still going?

Mr D.A. TEMPLEMAN: Silver Sands is going very well. The Premier should go there on a Saturday afternoon; they still have interesting activities there.

That is the context. I hope this new entity will continue to look at tackling the real issues that affect us with regard to alcohol. I agree with the member for Armadale; it is very unlikely that we will ever see an increase in the drinking age. It is a very sad pattern in Australian culture that we seem to have more and more problems with alcohol addiction and abuse and with "preloading" and all those sorts of terms that are used.

We have corresponding crime and antisocial behaviour as a result and, unfortunately, major incidents have occurred in Mandurah in the last five years. We had a spate of murders and I have said in this place before that I remember a period when I used to shudder at the weekend news when I heard that there had been a major assault, a glassing or even a murder, because invariably at that time it occurred in Mandurah and was usually as a result of alcohol or drug abuse. We had a spate of, I think, five murders in three months, including the savage bashing and death of a man at the Mandurah Crab Fest, not this year, but last year. There was a murder on a beach in Halls Head by an allegedly drug-addicted assailant. A series of murders shook the community and shocked us. The issue of drug and alcohol addiction remains a major concern for not only my community, but also communities throughout Western Australia and Australia. I think we have to be quite frank about it and face this with some fairly stark acceptance that there is a problem that needs to be addressed. One of the ways we can address it is through various programs that are proposed, but one of the frustrations I have had in recent times is being told, in the mental health area, for example, that there is no money for such programs.

[Member's time extended.]

Mr D.A. TEMPLEMAN: Those programs are aimed at addressing this issue at a grassroots level and, indeed, focusing on young people in particular, and focusing on them early. Many would know Heath Black, a former AFL footballer who is well publicised as having been an alcohol and drug-addicted young man, but who now works with beyondblue, the Black Dog Institute and others by going out to communities and highlighting what alcohol and drugs did to him. Only about a month ago I went to a seminar he delivered in front of nearly 500 young people from the Peel region. Heath has a very effective way of engaging with young people very, very quickly in his presentation, but his message is very clear, and I think it is extremely important. He is part of a program that has been attempting to get funding from this government, particularly from the mental health portfolio, to deliver the full tiers of a mental health–based program in Peel, but it cannot get the funding. I have appealed to the Minister for Mental Health and the government in this place through agitation and letters, but we keep getting told that there is no money for it. If this program could be delivered in its full capacity, it would deliver lasting benefits, particularly to young people in the region. One needs to remember that in the Peel region we are seeing a spike in the population growth in the zero to 15 years age group because an increasing number of young families now call the Peel home. I make this plea again, in the context of this bill, for the Youth Mental Health program operated by Eleanor—it is just chasing funding and about $300 000 will do it. The first tier is Heath Black's presentation, but it is the second and third tiers of that program that are crucial. They are the programs that then work into the schools and work down to individual young people. That is where the difference will be made, but at this stage this government and this minister still have not been able to assist us. Minister, again, it is a program that is deserving of prime royalties for regions funding, but we cannot wait for a blueprint and then for the minister to realise that there is an election coming up in two and a half years and for the funding to be held off until six months before the election in order to be able to say, "Aren't we wonderful because now we are delivering stuff to the Peel." A program like that should be delivered immediately and I plead with the Minister for Regional Development, if he has any sway in cabinet and he wants to deliver some money from royalties for regions for a very important project in the Peel region—it is not Mandurah-centric; it is Peel. All those local government authorities now ask the minister to consider it, because it is crucial.

I want to finish on another note. I do not mean this to be an attack on a particular group, but I want to highlight in this place one of my disappointments. However, first of all I want to congratulate Palmerston Association Inc. Palmerston has an office in Mandurah, and Sandra Harris and the team at Palmerston do a tremendous job in delivering services to families with family members and loved ones who have an alcohol and drug problem. Indeed, last Saturday week I went to a particular program that Palmerston in Mandurah had provided specifically for Indigenous families, and it was very successful. It was great to see Harry Nannup, the respected local Peel elder, there, as well as many Indigenous family members and key stakeholders together for a day talking about the issues of alcohol and drugs and their impact on families. It was very, very successful. I think Palmerston's work needs to be expanded. I am not 100 per cent sure where all of its funding comes from, but if we are to see investments in service provision in our region, again, that is one organisation that deserves strong support and further funding to address important support services for people in families affected by drug and alcohol abuse. However, I need to talk about Holyoake. Again, Holyoake is a well-known organisation with an admirable history. Unfortunately, Holyoake's services are not widespread in Mandurah anymore. They used to be and I need to highlight this issue to the house, because one of the concerns I have is the moral obligation of organisations to continue their work in places.

In the late 1970s and early 1980s, a number of community people, including a former reverend of one of our churches, Reverend Bob King, a firebrand reverend, established a house in Gibson Street in Mandurah, which eventually became a hostel for men suffering from alcohol abuse. Indeed, it provided them with not only a place to live, but also limited services. Over a period there were issues with the management of that place and eventually it was taken over under the management of Holyoake. For a number of years Holyoake provided a manager for that service and the house continued to operate as a hostel—it was the only one in Mandurah. Fortunately, the owner of the house, who was an elderly lady, gifted the house to Holyoake. Anyone who knows Mandurah will know that Gibson Street is one the older streets in the CBD. It starts on Mandurah Terrace and runs east–west up to Anstruther Road. Of course, in the early 2000s—around 2004—when land prices began to increase rapidly in Mandurah, particularly in the CBD, properties in that vicinity became very valuable. Unfortunately, the hostel closed because of management issues and, despite me calling in, I think, two of the CEOs, I heard that Holyoake had made a decision to sell the property. Holyoake sold that property for over $750 000, which was a significant return for that organisation. In the early days, Alcoa and community groups had contributed to set up that original home at 9 Gibson Street. Therefore, I asked Holyoake at the time what that meant for the provision of services in Mandurah, because in my view—I maintain this view to this day—Holyoake had realised an asset that the community had gifted to it, and it had a moral obligation to continue to provide these services to the Mandurah community. Unfortunately, at that time Holyoake was restructuring its services, and in my view the sale of that property was rationalised to enable Holyoake to deal with that

restructure. However, despite advocacy and Reverend Bob King coming to my office and demanding that we do something about this—because he also was arguing from the point of view of moral obligation—the property was sold, and the services to Mandurah are now being delivered from Victoria Park. Holyoake has two metropolitan-based offices—one in Victoria Park and one in Midland. It also has three regional offices—one in Northam, one in Narrogin and one in Merredin. I do not criticise Holyoake at all. I do not have a problem with its commitment. But Holyoake has a moral obligation to my community, given that it rationalised or realised a significant asset in selling that property. It is not as though the services that Holyoake provides are not needed in the Peel, given the problems that we face with drug and alcohol addiction. I therefore appeal again to Holyoake to consider expanding its services and its footprint into the Peel in a substantial way, given that it was able to realise some $750 000 to assist it with the restructure that it undertook in mid-2000.

The opposition has indicated, of course, that it will support this bill. But I hope that the specific comments that I have made tonight, particularly in relation to the need for programs in the Peel, will be heard by this government so that we can begin to address these issues. That includes not only domestic violence, and drug and alcohol abuse, but also the planning processes, which have disenfranchised the people in Greenfields and rendered their protests and their concerns almost invalid, because in a planning context, social issues are not considered to be issues for consideration.

DR G.G. JACOBS (Eyre) [9.11 pm]: I want to make a short contribution to support the Alcohol and Drug Authority Amendment Bill 2014 and to talk about the importance of making it possible for people who have both mental illness and addiction to alcohol and other drugs to access services. In the debate tonight, I want to make reference to comorbidities and what that means; to some experience that I have had with referral patterns and to how people access services; to the advantages of the amalgamation of the Alcohol and Drug Authority and the Mental Health Commission; and to some case accounts of the comorbidities and the impediments that exist in the present situation, where people have both a depressive illness and an alcohol problem, or, indeed, a schizoid illness or a schizophrenic illness and an addiction to tetrahydrocannabinol, or marijuana. The issue of comorbidity is very important, because for the diagnostician and the people who are trying to deliver and access services for the people who unfortunately are in this position, it is a matter of what comes first—is a person who is suffering from depression using alcohol in a self-medicating way to try to overcome or alleviate some of their depressive symptoms, or did the alcohol addiction come first, and are the long-term issues in and around alcoholism or dependence on alcohol causing the depressive condition? It is very difficult indeed to pigeonhole these conditions. It has often been the experience of the medical profession in referring people for these conditions that they have neither a pure depressive illness nor a pure alcohol dependence or alcohol addiction problem. However, very often the system says that this person has been referred to a particular door or a particular service because they have a depressive illness, when they also have an addiction to alcohol.

There has been a tendency for services to try to determine the primary morbidity, rather than look at the person as having a comorbidity and try to deal with those issues. I recount to members the story of a young man who by his own admission, after years of denial, admitted to alcohol dependence and sought to engage a rehabilitation service. It is often difficult in that rehabilitation to also engage mental health support and treatment. If nothing else comes from this bill, I hope that by subsuming the Alcohol and Drug Authority into the Mental Health Commission, we will be able to address the issue holistically for a person who is suffering and needs treatment, no matter whether the primary cause is depression or the primary cause is alcohol dependence. I believe the amalgamation of these services will deliver a better service for individuals who unfortunately find themselves in this position.

I also recount to you, Mr Acting Speaker (Mr P. Abetz), and the house that a lady who was living by herself started drinking, due to loneliness largely. She lost her husband prematurely. She became disconnected from her previous social networks as she translocated from her home town to my town. What transpired was a downward spiral into drinking, heavy drinking and then an alcohol dependence. What also followed were severe episodes of depression. These severe episodes of depression led to more drinking and an accelerated downward spiral into depression, memory loss and, indeed, some of the issues in and around a decreased cognitive function. Often people with severe depression such as this lady had are misdiagnosed as having dementia. This lady really needed a trigger to break the downward spiral that she was on. Often services say, "Well, is it actually an alcohol problem and she needs rehabilitation, or is it depression and she needs antidepressants and to go into hospital?" I have to say that in the referral to agencies, there was almost, if you like, a cop-out; that is, if the doctor referred the patient to one agency for the alcohol problem, that agency would say, "No, it's not an alcohol problem; this lady is depressed and needs to have treatment in a hospital with antidepressants." If the doctor referred the patient to the mental health system, the mental health system would say, "No, her primary problem is that she has alcohol dependence and needs to be rehabilitated from that alcohol dependence, and then the depression will get better." Basically, we had a diagnostic football that went back and forth. I believe that members of this place

would recognise that the primary diagnosis is of no consequence. We have a person who is suffering, and often illness is not one pure diagnostic label that someone can fulfil and therefore go into a certain pigeonhole. I believe that the recognition in this bill of that comorbidity and the ability of the services, whatever they be, to have flexibility with rehabilitation and treatment for depression or any other comorbidity is one of the advantages of this bill.

There is a serious comorbidity between other illnesses and mental illness. I recount that a young girl, after finishing school, went to work as a rouseabout in a shearing team. She had the occasional smoke of marijuana. It became more than an occasional smoke and became a serious addiction. Today that girl suffers from serious and severe schizophrenic illness. We now know from science and the scientific studies that have been done that there is an association between the abuse of marijuana—THC or tetrahydrocannabinol—and a schizoid illness. In fact, the younger the person starts the abuse of THC—for example, if they start smoking marijuana before the age of 15 years—the more likely they are to develop a schizoid illness later in their life. This girl developed a schizoid illness. Again, there was the comorbidity. Yes, we needed to deal with the drug addiction, but we also needed to treat her schizoid episodes. It was not a matter of having a pure diagnosis and providing her with medication; her rehabilitation and her addiction to marijuana also had to be dealt with.

I recount those things to you, Mr Acting Speaker, and the house because I believe that recognition of the comorbidity is an important part of this bill and the amalgamation of the Alcohol and Drug Authority with the Mental Health Commission. It has been said that the functions of the current Drug and Alcohol Office will be lost; they will be swallowed up—this is a subsuming—and all the good work that the Drug and Alcohol Office has done in the past will be lost. I do not believe that is true. As we have said, I believe that this is a recognition of the person as a whole and the issues that need to be dealt with. In fact, Professor Bryant Stokes, in his 2012 review, referred to the discharge and transfer practices of public mental health facilities and services in Western Australia. The Stokes report outlined that access to services is difficult for patients with combined mental illness and drug and alcohol conditions. The case that I bring to the house tonight is that the purpose of the bill is not about saying, "This is a medical problem that needs treatment. This is the primary cause, or the addiction is the primary cause." In fact, the purpose of the bill is to deal with the combined mental illness and drug and alcohol conditions for the betterment of people who find themselves in this situation. I commend the bill to the house.

MRS M.H. ROBERTS (Midland) [9.27 pm]: The issue of drug and alcohol abuse is one of the most serious issues confronting the community of Western Australia. Indeed, it is a serious issue confronting people in Australia and around the world. I want to commend in particular the members who have so far made a contribution to the debate on the Alcohol and Drug Authority Amendment Bill 2014. Although some might think that this is a pretty simple matter of amalgamating the authority with the department, I believe it gives us an opportunity to focus on one of the core issues at the heart of Western Australia. Alcohol and drug abuse is wrecking lives over the length and breadth of this state. We have a government that often talks tough on crime. It says that it is going to toughen the laws and increase the penalties. That does not count for much if people are total unaware of what the penalties are when they commit various crimes. When people are off their face on amphetamines or other drugs or turn to alcohol abuse, they get involved in a lot of crimes as a result.

I have responsibility for the opposition for the portfolios of police, crime prevention and road safety. The issues with alcohol and drugs are big issues for those portfolios. It is not good enough for the government to be so-called tough on crime and to have some glib one-liners about tough penalties and how many more people it is going to lock up. It needs to deal with the causes of crime. Alcohol and drug abuse is driving much crime in this state and, indeed, around Australia. It is also driving the high mortality and crash rates on our roads. It is believed that at least one-third of crashes on Western Australian roads have alcohol or drugs as the major contributing factor. If we did not have that issue with alcohol and drug abuse, we could reduce the road toll dramatically. It is not just the road toll, as each week in Western Australia people suffer from the consequences of serious road crashes, and they and their families live with debilitating problems for the rest of their lives. When a young person gets hooked on alcohol or other drugs, particularly amphetamines, heroin or cocaine, it impacts on not just their life, but the lives of their family, friends and the community around them. From my way of thinking, we should be dealing with this because of the individuals involved. I feel pretty sad knowing that young people in our community just 12, 13 and 14 years of age are already out there binge drinking and experimenting with mind-altering drugs.

Although I have appreciated all the very good comments made in tonight's debate, I particularly want to commend the member for Maylands and the member for Eyre, both of whom delivered exceedingly well researched speeches with the best of intentions. The member for Maylands took up a community campaign to oppose a Liquorland store in Maylands in her electorate. She worked with the community there so the store would not get planning approval, and then opposed it getting a liquor licence. In that case that community had

a win. I will not repeat the arguments of the member for Maylands because I have some other arguments to get on with, but she explained in the course of her speech that the prevalence of alcohol and alcohol advertising and the availability of alcohol in the community has a huge impact on the uptake of alcohol by young people. If it is in people's faces every day when they watch television or sport—very much like the cigarette advertisements of old—they see alcohol associated with fun, sport and popularity. If people are having a beer or another drink, such as some kind of mixer, it is smiling faces, people in happy social occasions, playing sport, watching sport and having fun. If people want to be part of the hip crowd, part of the popular crowd, and one of those people having fun in their life, they have to get involved with alcohol.

I take issue here with one of the state government's own advertisements. A Western Australian Office of Road Safety advertisement has a catchline, "You deserve it." If a person has done this or that, they deserve to drink, but then they tell people not to drink and drive. The message in that advertisement is that it is okay to have a drink; and if people achieve something, it is great to celebrate and have a drink, "You deserve it, but don't drive afterwards." I am not a wowser. I am not saying that people should not be able to drink in moderation or that a glass of champagne, wine or a beer to celebrate an occasion is not appropriate. I am saying that alcohol abuse is not appropriate.

It is also not appropriate for young people to abuse alcohol. As the member for Eyre very eloquently pointed out—again, I will not go into the detail of his argument, but the comments he made fit very well with what I have read on the topic—exposure to cannabis, basically smoking cannabis, I think he said before the age of 15, can have very serious consequences in schizoid illnesses and the like later in life. The member for Maylands pointed out that the earlier a person is exposed to alcohol and drinks alcohol, to cut a long story short, the much more likely it is they will become an alcoholic and suffer all the issues associated with being an alcoholic. In the course of her speech, the member for Maylands dispelled a number of myths, such as it is okay to give kids a little sip of wine because it is better that they get used to alcohol in the home environment and that perhaps parents should share some wine or something else with their 12, 13 or 14-year-old or for that matter even their 15 or 16-year-old. For any parents out there who are in any doubt, the clear evidence is that the later someone starts drinking alcohol, the less likely it will be that they will ever have a problem with alcohol abuse. The earlier a person starts drinking alcohol, the more likely it is that they will have chronic alcoholism problems as they get older. Likewise with cannabis or other drug abuse; the earlier a person starts to use drugs the more likely they will have problems. It is not just that there will be a greater consequence or likelihood of them continuing to be involved in heavy drug use, but essentially young people's brains are still forming and developing. Unlike the member for Eyre, I am not a doctor but from what I understand, in very layman's terms, neural pathways and things are still being formed; the brain is still developing. As road safety minister, I got lots of briefings about brain development and cognitive development, certainly up to the age of about 25. One thing we see, particularly with young men, is that a lot of risk-taking and other activities lead them to be involved at a much higher rate in road crashes and, therefore, mortality and serious injury on our roads.

These are the most serious issues confronting our community. These are the things we need to deal with, because we need to protect and save as many young people as we can in our community and provide them with the opportunity to grow into adulthood and have a productive life, able to get an education and a job, to have a family and fully participate and contribute in our community. If that is what we want for young people, we have to do an awful lot more, because all I have seen over the last 20 years is more and more young people at an earlier and earlier age getting involved with both drugs and alcohol.

One of the things that I say to young people is that they have choices, and they have to make sensible choices. One of the things they have to take them through life is their brain. That is what will help them when they want to get a job and when they want to make choices about future occupations, relationships and a range of things. Why do something that will harm their brain? In the same way that cigarettes harm people's lungs and other organs, alcohol and drug abuse does serious and potentially long-term damage to their brain that they can never recover from. Effectively, they will handicap themselves for the rest of their life when they do those things. We need to do much more, principally for the sake of the young people involved and also for their families and the consequences for them and the community. The other reason we need to do much more is that a failure to act is having an awful consequence on the rest of the community, because when somebody young, or older, gets involved in alcohol or drug abuse and gets behind the wheel of a car, it is not necessarily just their life that they put in jeopardy; they put my life, my children's lives and everyone else's life in jeopardy when they do that. The consequence may not just be that they run off the road and hit a tree; they may be involved in a head-on collision with another vehicle. Innocent parties who were not involved in alcohol or drug abuse, who were driving at the speed limit, who were not fatigued and who were following all the road rules could end up bearing the consequence of this. Indeed, the offender who did the wrong thing will live with the consequences for the rest of their life too. I do not believe anyone wants to have on their conscience the killing or maiming of another human

being. People do not intend to carry out these offences but they can do so when under the influence of alcohol or drugs.

In the time available to me tonight, I will not have the opportunity to quote from a lot of research papers. I wish to note the cost of hospitalising people who are seriously injured on our roads. I want to reiterate that first and foremost I am concerned about those individuals and the impact on their lives and those of their family. We also need to know that there is a huge cost to the community in hospitalising people and potentially providing medical treatment and support for those people for the rest of their lives. I used to work in the area of occupational health and safety. People who have a problem with alcohol or drug abuse have more time off work and they are less productive than other workers. Young people who get hooked on drugs or alcohol at an early age and who perhaps, as the member for Eyre suggested, go on to develop schizoid or other mental illness because of the damage that they have done to their brain at an early age, do not, frankly, have the opportunity to be productive members of our community. Their chances of gaining a good education are extremely limited. Their chances of obtaining and holding down a job are extremely limited. Worse than that, their chances of being involved in crime are very high. People who abuse alcohol or drugs are much more likely to perpetrate a crime and eventually end up in prison. The consequences of not doing anything or of not doing a lot more than we are currently doing means that we will be writing off further generations of young people and we will be paying an enormous amount to incarcerate those people for vast portions of their lives. The costs to the health system, including hospitals and health care, are huge. We wonder why the health budget has to grow so much each year. The costs in police time, court time and prison officers' time and building more prisons to accommodate people are astronomical. There are further reports on the time lost in work and opportunities. If we add all that up, we would certainly realise that not doing anything or not doing enough has huge consequences on government expenditure and therefore public expenditure. The only way we can deal with that is generally by putting up taxes. Eventually we will have to pay more because of the failure to act or, as other people have said, failure to have early interventions in place. Failure to regulate alcohol and drugs in our community and to do something about it leads to personal, family and community tragedy and places a huge cost burden on every taxpayer in Australia.

[Member's time extended.]

Mrs M.H. ROBERTS: I want to refer to a couple of studies in an area that have not been referred to by other speakers in the debate so far. There are some very strong links between amphetamine use and crime. A 10-year research study from 1999 to 2009 was released in 2012 relating to detainees at the East Perth lockup and amphetamine users versus non-users as indicated by urine tests and crime charges. It basically concluded that amphetamine users are almost twice as likely to be charged with robbery, extortion and related break and enter offences, and theft and related offences. Their involvement in overall property crime is dramatically higher than the general community. There is an extremely strong link between amphetamine use and property crime. The point that I wish to reinforce is that when someone is high on amphetamines and doing crazy things, they do not give a moment's thought to the penalty. I do not say that because I do not think they should be penalised or they should get a lesser penalty—not at all. I am just saying that if we want to prevent crime and stop this happening in the first place, not just for the benefit of the offender but more particularly for the benefit of the victim, we have to do something that works and that prevents the crime from occurring in the first place. I would like to see a reduction in crime. One of the ways that we can reduce the level of crime in our community and have fewer victims of crime in our community is by confronting an issue such as amphetamine abuse. Unfortunately, Western Australia's record is worse than other states in Australia. That report advises that WA recorded a dramatic increase in amphetamine-related admissions in the 2010–11 financial year, peaking at 500 per million persons. This figure is double that of the 2009–10 financial year, when it was 252 per million persons. That is over a two-year period. From 2009–10, it was 252 per million persons and by 2010–11, it had peaked at 500 per million persons. Surely a doubling in two years has to ring alarm bells. I have seen nothing in the past couple of years since that report was released that would reduce that trend in any way. There has been a big increase in hospital admissions for amphetamine dependence in WA. I have some further figures that I will not get into the detail of, but they continue to paint that disturbing picture.

The first report I referred to related to people admitted to the East Perth lockup who had volunteered for urine analysis. It demonstrated that we have a much higher amphetamine use than anywhere in Australia. The other report that I want to briefly refer to was prepared by the National Drug and Alcohol Research Centre. It is entitled "Drug-related hospital stays in Australia 1993–2011". By way of introduction, it states —

> This bulletin presents data on drug-related hospital separations in Australia from 1993-2011 for the following drug types: opioids, cocaine, amphetamines and cannabis.

It goes on to refer to how it got its data. Some jurisdictional analysis is provided under each of those headings. On page 4 of the 12-page report is the heading "Amphetamine-related hospital separations". Under "Jurisdictional Analysis" it states —

- Amphetamine-related separations have been highest in WA, NSW and South Australia (SA).
- WA recorded a dramatic increase in amphetamine-related separations in 2010/11, with separations peaking at 500 per million persons. This figure is double that from 2009/10 (252 per million persons).
- The increase in WA is largely due to separations for amphetamine dependence, which accounted for nearly half (46%) of all amphetamine-related separations in 2010/11 compared to one-third (32%) in 2009/10.

I note by way of comparison that under "Jurisdictional Analysis" the report goes on to state —

- Separations in NSW have been declining since 2006/07, from a peak of 291 per million persons to 183 in 2010/11.

That is interesting, is it not? It is not that amphetamine use and so forth is increasing everywhere around Australia; it is dramatically increasing here in the west while bigger jurisdictions, such as New South Wales, which we might imagine to have a worse problem, have managed to get their figures down. The separations in New South Wales in 2010–11 were 183 per million persons and in the same year in WA there were 500 per million persons. I am not an expert on the analysis of these things; I have simply read the core lines that show those jurisdictional comparisons and I have quoted, as I understand it, independent experts. These are the kinds of issues that we need to look at in Western Australia. What is driving amphetamine use here? Why is it so much higher here than in other states? Is it availability? Is it because people working in the mining industry are more cashed up? Is it somehow connected with what we are doing or not doing in our schools, or the services we are providing? This is absolutely important and absolutely urgent because it is wrecking people's lives and their families' lives and in the short and long term it is costing the community a phenomenal amount of money.

A section on a subsequent page is headed "Cannabis-related hospital separations" and under "Jurisdictional Analysis" it states —

- WA has recorded dramatic increases over the past 3 years from 76 cannabis-related separations per million persons in 2007/08 to 166 in 2010/11. In 2010/11 nearly two-thirds (61%) of these separations were due to cannabis dependence.

Far from things improving, things have gone backwards in this area as well. Maybe someone thinks that this bill will somehow deal with these issues. I do not think so. This bill deals with the mechanics and not with the issues. I am not saying that this legislation will make the situation worse, but I certainly have my doubts about whether it will make it better. I doubt whether the government understands the importance of this issue to the community and the impact that it is having on many people.

I refer to crime and drug use. As I pointed out from the data provided, amphetamine use is a driver of property crime in particular. I note that in Western Australia we are still not catching most home burglars. The police recently put up their 2013–14 financial year crime statistics for the state, for the metropolitan region and for each of its districts. I note that the sanction rate for home burglary was just 8.9 per cent. In over 91 per cent of home burglaries there was no sanction. In my electorate, which is in the east metropolitan region, the sanction rate was just 8.3 per cent. The member for Armadale is getting excited because the south east has had a special Frontline 2020 trial, but the sanction rate for home burglary in the south east metropolitan area was only 8.6 per cent, which is below the metropolitan area average. The average for the sanction rate for home burglary in the metropolitan area was 8.9 per cent; east metro, 8.3 per cent; and south metro 8.6 per cent. The districts that are driving up the figure a little are generally in the country areas. There is a much better sanction rate for home burglaries in almost all country regions. I suspect that that has something to do with the nature of policing in those smaller communities. But, again, many country regions have double the sanction rate that we have in parts of the metropolitan area.

In conclusion, I think that this is one of the biggest issues of our time, if not the biggest issue. It really disturbs me that the community and the government allows drug and alcohol abuse by so many young people. I do not think that it is solely a government responsibility. As a community we need to act. As parents we need to act. As aunts, uncles, grandparents, whoever we are, we need to make a stand and let the government know that we expect the government to make a stand with us. This is an area of priority. If I were in the Premier's position, I would not want my legacy to be a few shiny buildings. I would want my legacy to be driving down the rate of involvement of young people in things such as drug and alcohol abuse. I would be more interested in making

a difference to their lives and their families' lives and their future for not only their benefit, but also the long-term financial and productivity benefit of the whole community.

MR C.J. BARNETT (Cottesloe — Premier) [9.57 pm] — in reply: I wish to make a few comments in reply to the second reading debate on the Alcohol and Drug Authority Amendment Bill 2014. I will not be long at all and this will bring the second reading stage to a conclusion. I acknowledge the support of members opposite for this bill. It is quite a simple machinery-of-government bill to bring the Drug and Alcohol Office within the Mental Health Commission. The member for Kwinana indicated support for the bill. He was concerned that the drug and alcohol component might lose its identity. In a sense, the name might imply that, but there will certainly be an area within the Mental Health Commission that will specialise in treating drug and alcohol abuse. There is a coincidence of mental illness and drug and alcohol abuse. Whether mental health leads to substance abuse or the other way around will vary from patient to patient, but there is certainly not a need for two services and two organisations to be operating in this field. It makes sense to bring them together to work on both mental health issues and drug and alcohol abuse in a coordinated agency, particularly when we have to reach out into far-flung and remote parts of the state to deliver services. Although a person may come from an alcohol and drug treatment background, they can also deal with people with mental health issues whatever the causation, if they happen to co-exist. It is logical and sensible to leave the name as the Mental Health Commission because something such as "Mental Health and Drug and Alcohol Commission" would simply reinforce and continue a silo mentality. We want these people to work together. An expert on alcohol issues can deal with someone with or without a mental health condition. The rationale for the bill is as simple as that.

The member for Maylands talked about an issue that concerns many members of Parliament—that is, the very aggressive advertising of alcohol outlets. That is a growing problem in our community. It is also an issue of managing venues. In my case, for a long time there have been problems at beachside hotels. Fortunately, now the management of those is a lot better; they have gone upmarket and that has tended to reduce antisocial behaviour. She also mentioned the issue of young people and alcohol.

The member for Armadale made the suggestion that board appointments should follow specific categories. I understand the importance of having professionals in different areas, but I would certainly resist categorising that there must be a certain composition of the board. In most areas they are actually going the opposite way. I would hope that we get that mix of skills, but trying to have a representative board, whether it is representing outside organisations or professions, has failed in government. I just make the point that the cabinet, not the minister, makes the decision, so we get that rounded discussion. The member for Mandurah talked about some of the issues in his electorate. I think we all have issues of mental health and alcohol and drug abuse in our electorates.

The member for Eyre very clearly made the point about comorbidity. I think this is true, and we really need to step forward. Does mental illness bring a stigma to alcohol abuse, or does alcohol and drug abuse bring a stigma to mental illness? I think we just have to move on. The community has gone past that now. A lot of the stigma of mental health has disappeared, and so often they are related in one way or another. Anyone working in the mental health area will say that the biggest dramas they have involve people heavily intoxicated or heavily affected by drugs, and violent behaviour in emergency departments and the like. That is part of a growing problem in health.

I do not remember what the member for Midland may have said some years ago, but I must take some exception to what she said, though not as an individual. I am one of the few members that were here in this chamber 10 years ago, during the Gallop government. Maybe it was a different era, and amphetamines were not around so much and probably heroin was the drug that led to a lot of deaths, particularly during the late 1990s. A lot of young people died from heroin overdoses.

Mrs M.H. Roberts: That was when you were Minister for Education. You were in government in the late 1990s.

Mr C.J. BARNETT: Yes, I was. What the member for Midland said today was an attempt to rewrite history. I do not know what the member for Midland said at the time, but I certainly know what the Labor Party said during the time of the Gallop government. I was sitting on the other side listening to it. I have been thrown out of this chamber once in my life, and that was over the drugs debate. I probably deserved to be thrown out, but I was so incensed with what happened under the Gallop government, when laws were brought in to allow increased possession of cannabis, to the point of a tradable quantity—a marketable quantity of cannabis. People were given the right to grow their own plants. The tenor of the debate in this chamber was along the lines that cannabis is okay; many people have smoked it and it is not a gateway drug. It does not lead on to anything else. That was the argument.

Mrs M.H. Roberts: What I quoted before stated that the problem has got much worse in the past three years.

Mr C.J. BARNETT: I know what the member said tonight.

Mrs M.H. Roberts: Independent statistics show that it is a much worse problem now than it was then.

Mr C.J. BARNETT: Yes, but listen to what I say.

Mrs M.H. Roberts: Your regime hasn't worked.

Mr C.J. BARNETT: The member for Midland cannot rewrite history. I am just going to correct the record.

Mrs M.H. Roberts: You're the one who is rewriting history.

Mr C.J. BARNETT: Members of the Labor government under Premier Gallop argued, first, that cannabis was not a gateway drug. The second argument was that the emerging amphetamines at the time were simply social drugs and party drugs.

Mrs M.H. Roberts: That is simply not true; you are rewriting history.

Mr C.J. BARNETT: Those are terms the then government used repeatedly in this house. Go back and read *Hansard* and read what the Labor Party in government said.

Mrs M.H. Roberts: I know what the result was. There is a much worse drug problem now than there was then, and much worse than every other state. That is your legacy.

Mr C.J. BARNETT: The member for Midland cannot rewrite history.

The ACTING SPEAKER (Mr P. Abetz): Member for Midland, I call you to order for the third time.

Mr C.J. BARNETT: That was the argument, and the legislation was brought in that made cannabis more available and gave an impression to young people in particular that cannabis was okay, and that social and party drugs were not really a threat. That was the image.

Mrs M.H. Roberts interjected.

Mr C.J. BARNETT: I was here, and I took absolute exception to that, and that is when I was thrown out of the Parliament. I remember going to a function that night and admitting that I had just been thrown out of Parliament. I was a bit embarrassed. I said that I was thrown out of Parliament because I stood up against the Gallop laws on cannabis and so on. I got a round of applause from about 300 people for doing it. I did not expect it, but that is what happened. I will tell members something else about what happened at the time. My frustration about it was that I could find virtually no-one in the community who was prepared to speak out against these changes the Gallop government brought in on drugs, except for two people. I approached some leading people in the health sector—public figures—and asked why they were not speaking out about the dangers of cannabis with these so-called social and party drugs. I will not name the people, but one of the answers was, "I agree with you, Colin, but it is too political." That was one of the most disappointing comments I have heard from a leading Western Australian at the time. One person who did speak out was Bishop Chris Saunders of Broome. Some members may know him or remember him. I know the member for Midland does.

Mrs M.H. Roberts: I know Chris Saunders.

Mr C.J. BARNETT: I am sure the member does. He is a very good man. He was the first person to speak out outside of this chamber, and he talked about what a damaging effect increased availability and usage of cannabis would have on Aboriginal people. He was dead right. He was about the only prominent person in this state who had the courage to speak out.

The other group I want to talk about is a group of young girls in an organisation called Esther House. There was denial in the media and the Labor government was winning the argument. The media were saying that these were just social or party drugs; cannabis is okay, we have all had a puff and it did not hurt us. The media were onside with the Labor government at the time. The Esther House group, which some members would know of, made contact with me. Esther House looks after young women and girls from as young as about 12 to about 21 or 22 years of age who had got into drugs and prostitution and broken away from their families. This was a group of people getting their lives back into order. To this day I have remained a supporter and I have been able to help them in a few little ways along the way. I remember having a press conference at Esther House. I still have a photograph of probably about 15 or 20 young girls aged from 12 years to early 20s standing behind me. I said much the same as I am saying today about drugs. I do not pretend to be an expert on drugs. I have not even smoked cannabis in my life—not even a puff—but I do not claim any puritanical ability because of that; it is just a reality. I asked some of these girls —

Mrs M.H. Roberts: Why have we got the most dramatic increase in drug abuse of any state? We have more hospitalisations.

Mr C.J. BARNETT: The member for Midland does not like to hear this, but she is going to hear it.

I had these 10 or 15 girls behind me, and I asked them to tell their stories. Their stories were so remarkably similar, one by one. They started drinking alcohol and then tried cannabis. Then they were into amphetamines, which were becoming available at the time.

Mrs M.H. Roberts interjected.

Mr C.J. BARNETT: These brave young girls—they were brave; they were kids—then sometimes got into prostitution, heroin and the like. Their lives were all but destroyed but for the work of Esther House. I am proud that this government has supported Esther House in a number of ways.

Mrs M.H. Roberts: What is happening about the house in Kalamunda?

Mr C.J. BARNETT: It is a pity the member for Midland would not support it.

Mrs M.H. Roberts: I do support Esther House.

Mr C.J. BARNETT: We have heard from the member for Midland.

Mrs M.H. Roberts interjected.

Suspension of Member

The ACTING SPEAKER (Mr P. Abetz): Member for Midland, I ask you to leave the chamber. You have been called three times; this is the fourth time. It is time to leave.

[The member for Midland left the chamber.]

Debate Resumed

Mr C.J. BARNETT: This government purchased a building for Esther House. There needs to be a substantial amount of rehabilitation, which is happening, and it will be occupied by the Esther Foundation. The Esther Foundation is one of a number of different organisations, but they were the only two—Bishop Chris Saunders in Broome and the young kids of Esther House—who had the courage to speak out. I can still remember a number of young women journalists there, who probably had had pretty safe and privileged lives, with tears in their eyes, shocked at the personal stories of these brave young kids. They had all but lost their lives in every sense and had the courage to speak out to the people of Western Australia about the reality that, yes, cannabis did lead to worse drugs and, yes, alcohol was part of it, and what that meant to their lives. Most of those kids have probably survived and are living productive lives. They have gone back to education. Some had babies—they were 15-year-olds with babies and all the rest of it. That was the environment of 10 years ago.

Ms M.M. Quirk interjected.

The ACTING SPEAKER: Member for Girrawheen! How many times has the call been given? One. I call you for the second time.

Mr C.J. BARNETT: I am appreciative of the support of the opposition. I am appreciative of the fact that the member for Midland now seems to have a very different attitude from the one that the Labor government had 10 years ago. What I think offended so many people most was that the message that went out from the Gallop government was entirely the wrong message to young people about drugs, in particular, and having an attitude. It was an error; we all make errors. It was a catastrophic error for a generation of young Western Australians. To hear Labor members from that era who sat through that debate say tonight, as the member for Midland did — I am sorry she is not here actually—what a pity it is that there is now a government that allows alcohol and drug abuse is an absolute insult to me and to everyone who fought that campaign about the so-called Gallop drug reforms. History cannot be rewritten. It is there in *Hansard*, as it is being recorded tonight. I invite some of the newer members, if they wish, to read some of those debates about what the Labor Party in government had to say on drugs—social drugs are not a problem—basically freeing it up.

I will conclude with this: what has this government done?

Ms M.M. Quirk: We had a drug summit and we called in experts.

Mr C.J. BARNETT: Yes, what did the Labor government do? It allowed two cannabis plants to be grown, increased the amount of allowable cannabis and told young kids that cannabis did not lead to higher drug use. It was a disgraceful performance against the youth of Western Australia.

Mr R.H. Cook: Just take a chill pill; forget the feigned outrage.

Mr C.J. BARNETT: No, forget it. I will not get thrown out tonight.

Several members interjected.

The ACTING SPEAKER: Members! Member for Kwinana!

Mr C.J. BARNETT: The member for Kwinana was not here. I think he would have been ashamed of what the Gallop —

Ms M.M. Quirk: You are absolutely verballing.

Mr C.J. BARNETT: Go back and read the speeches. The member for Girrawheen was there and I do not remember her speaking out on behalf of young people on drugs. I do not remember her getting up and saying anything. I do not remember her saying a thing.

I will conclude with this because I have made my point. Anyone who doubts my version of events can read *Hansard* from 10 years ago. Thank goodness we have got Hansard.

Under this government, the problem is probably greater. There are a lot of drugs in our society and use of drugs in Western Australia is high; it is a huge problem. Mental health issues are sort of coming out from under the bed, I guess. People are now more open about mental health and dealing with it. I do not want to labour the issues with the former member for Vasse, but I have not seen a worse display of behaviour than members opposite ridiculing and abusing a member of Parliament after he had been clearly diagnosed as bipolar and having suffered a severe depression.

Ms M.M. Quirk: You did not share that with us for over six weeks.

Mr C.J. BARNETT: It was public from the moment that the former member for Vasse resigned from cabinet. I am not denying there were political issues in that, but once the opposition knew he had a severe mental health condition—he was under medical care, on a drugs program, obviously, and had been hospitalised—it did not stop. The opposition continued to abuse the member for Vasse. For the Labor Party to now try to pretend that it has some sanctimonious caring approach to mental health and drug abuse is hypocritical in the extreme.

I conclude with this: what has this government done? I agree with the member for Midland that this is a huge problem in our community. The first thing we did was to repeal the provisions of the drugs law that the Gallop government had brought in. We immediately appointed a mental health minister, the member for Eyre; we gave a ministerial focus on mental health. We established the Mental Health Commission to make mental health somewhat separate from the mainstream health services. We have invested in better residential care and we will do more of that. We are currently looking at the future of Graylands, which as an institutional setting is somewhat Dickensian in nature, and we have taken a tough stand on drugs compared with the previous government—there is no doubt about that. I do not deny that there is a lot more to be done, but the one thing that cannot be done is to walk into this chamber and try to rewrite history. It was hypocritical, it was disrespectful to people with mental health issues and it was unrealistic and unforgiving on drugs. To some extent I now feel proud that I was thrown out of the chamber in far better circumstances than the member for Midland just was.

Question put and passed.

Bill read a second time.

House adjourned at 10.16 pm