T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the use of cannabis in Victoria

Beechworth – 28 April 2021

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WITNESSES

Andrew Hick, Manager, Circuit Breaker program, Odyssey House Victoria.

The CHAIR: Andrew, thank you, thanks for your patience.

MR HICK: My pleasure. How's it going?

The CHAIR: Yes, really well, thank you, really well. Yes, thanks Andrew. I apologise, we've run a bit over and once you start running over it just — —

MR HICK: Yes, like a doctor's surgery.

The CHAIR: Yes, it just seems to get more and more. Where are you based, Andrew?

MR HICK: We are based at Molyullah. I am the manager of Circuit Breaker program at Odyssey House. Molyullah is about 15, 16 kilometres outside of Benalla, in between Benalla and Wangaratta.

The CHAIR: Yes, got you. I have been hearing about it because we've been advocating for something similar in Mildura and they keep talking about it.

MR HICK: We have a lot of clients from Swan Hill and Mildura; we are the closest available facility. I think we've got one or two in there at the moment in there from Mildura.

The CHAIR: Yes, fantastic.

MR HICK: And I encourage you to continue your advocacy.

The CHAIR: Thank you, thank you. We'll get going now everyone's here - fantastic, thanks Andrew. Again, thank you very much for appearing today — —

MR HICK: My pleasure.

The CHAIR: If I could just let you know that all evidence taken at this hearing is protected by parliamentary privilege and that is provided under our Constitution Act but also the standing orders of the legislative council. Therefore, any information that you provide today, is protected by law. However, if you were to repeat any of the comments outside, you may not have the same protection. And any deliberately false evidence or misleading of the committee could be considered a contempt of Parliament. As you can see, we are recording today; you will receive a transcript of the hearing today, and we encourage you just to have a quick look at that to make sure that we haven't misrepresented you or misspelt your name or anything like that.

It will ultimately form part of the report, and also go up onto our website. Again, Andrew, thank you so much for coming today. If you'd like to make some opening remarks, and then we will open it up for conversation.

MR HICK: I know you're short of time and I haven't got a huge amount of opening remarks - I am Andrew Hick; I am the manager of the Circuit Breaker - Odyssey House Circuit Breaker program in Benalla. It is a 15-bed program. We have nine male bed, six female beds. We are out in the countryside, about 40 acres, a lovely property, beautiful spot. At the moment, we are going through a planning process to increase our beds to 30 to 35 beds. That includes building a new building and repurposing some of the old farmhouses we have right now. However, we are going through planning — and we've got a lot of support in the local community We are a well-supported program, but only our neighbours are anxious about what this might mean for them, and it looks like we may have to go to VCAT. Anyway, it is very frustrating and a lot of work and so on and so forth.

We have been going since 2005, on and off . We've closed twice in the early years; we didn't have enough funding. We are federally funded. If and when we increase our beds, we are hoping that we will move 15 beds up from the Odyssey House at Lower Plenty, and we will then be running two funding streams, one federally and one State funded. We have clients from all over the State. Until the Hope Centre at Bairnsdale opened we were the only other Odyssey House apart from Lower Plenty.

Now, traditionally in Victoria, there has been a lack of what we call therapeutic community beds — you might call them resi-rehab beds — compared to New South Wales. New South Wales would have had between 800

and a thousand beds, whereas Victoria had about 200, with a similar population. Our waiting list is always full, we have between — I checked the other day — we have 82 on our waitlist. We usually have between 80 and 110 people on the list.

Around about a third of people who are on that list will get to Circuit Breaker, and of that, about 60 per cent will complete the program, which is a good percentage. It's a six week program, it is 42 days. About 15 per cent go on to long-term rehab. Some will repeat the program. Others will do our six weeks and go off and live wonderful, beautiful lives, yet some will repeat the program several times. Some we do not know what happens to; others will die, and that is the nature of the work we do.

(Indistinct) is the subject of the inquiry; over 80 per cent of the people who come to us will have used cannabis at one time or another but we really look at primary drug of choice and the two primary drugs of choice for people attending our program are methamphetamine/ice and alcohol. That said, almost everyone uses cannabis; almost everyone uses tobacco, a lot of people drink; most people drink. Other people — we have some heroin users but there's probably only one in 10, something along those lines.

We struggle for funding. It's the nature of the beast and all of those sorts of things. Aside from inflation regarding wages, we are still getting the same funding we were in 2009 which makes it difficult for us. However, we are grateful to be there and we manage and we produce a good service.

I'll give you a brief run-down of a day at Circuit Breaker. The residents get up at 7 o'clock in the morning. There's a period of time where they all have breakfast together. People can tidy their rooms, have a shave, have a shower. It is expected that your room is tidy, it is expected that if you're a male you will have had a shave in the morning, your clothes will be clean, your room will be spick and span.

Then we have a morning meeting where we set up the business of the day, and it really is a business meeting. 'You will be doing this, you guys will be working here; we are expecting these people onsite at this time, this is what's for lunch, these are the chores that you have, you have and you have, and then we jump into the day.' Residents are given meaningful work tasks in the morning and that is to get back into the routine of what a working man or woman does — what I am sure we all do.

We work around the properties, like, the animal husbandry or cleaning or painting or sometimes we have specific and special projects. The residents do 95 per cent of the cooking. You will be there for a few days, then we will chuck you in the kitchen and you will be cooking a meal for 20 people, and it is expected to be good food, on time, made safely. We help, but in the afternoon, we will have a group — we might be running a cognitive behavioural therapy group or looking at some of those self-destructive patterns that a lot of our residents show.

Chores are after the group when everyone gets home in the evening (indistinct) me. I'll be doing various things around the house and we expect the residents to do the same. Then there's activities in the evening. That might be attending 12-step groups, it might be a topic group that we have on the property. It might be a fun night where we've got a quiz or an arts night, or once a week we basically we strip the kitchen down and clean it from top to bottom, which we call GI, which is a team building exercise for everyone.

Residents are the protagonists of their own treatment. Everyone else is a facilitator there, and we only have four rules, and the rules are: no sex; no drugs; no stealing; no violence or threats of violence. If you break one of those rules, then you're immediately discharged and you can't return, depending on what it is you've done, and you can't return while anyone else is in the program with you. Because if you've threatened someone with violence, you can't expect that person to then have a safe — I am sure I do not need to explain to you. That only happens a couple of times a year.

Everything else is up for negotiation. All of our standards are up for negotiation, and the residents have a say in how we run the program. There are various opportunities throughout the work week for the residents to talk about what it is we are doing, and what should we be doing, and so forth. As part of that, on Monday I asked some of the residents to get together and produce a document, I told them I was attending here and was there anything that they would like me to pass on to you guys. Although the meeting was facilitated, the facilitator didn't have any say in what they've written, or what they put down as a final statements, the residents have written that statement themselves and typed it up and photocopied it for everyone.

One of the things we do at Circuit Breaker is we expect high standards from all of our - from our staff and from our residents too. We want them to aspire and achieve and we believe that if we hold the bar here, they'd probably get to here, so we hold the bar here and they get to here, and I am a firm believer in their capacity as individuals and as a group. I do not know if that document they produced will be helpful, but it was certainly helpful to them, from a therapeutic point of view, to have that conversation and go through the process.

The CHAIR: It's great, and thank you, Andrew. Certainly this committee, in particular, is very interested in those with lived experience and — —

MR HICK: Can I just answer that — —

The CHAIR: Yes.

MR HICK: Look, I have my own lived experience, as do 77 per cent of the staff at Circuit Breaker. It is not something I often bring up, but it seemed to be protected by parliamentary privilege. I am in recovery and by being in recovery what it means is that I haven't taken any drugs or alcohol for nearly 25 years. I went through a program myself in 97, 96, quite a while ago. I say that because it might be relevant to what I am going to say for the rest of the questions and answers, but also I think that perhaps people who are in that recovery community, for want of a better phrase, do not often say it out loud, and I think the more people that do, probably the better off we'd all be.

Dr KIEU: Thank you for appearing here today and congratulations on your personal success — —

MR HICK: Thank you.

Dr KIEU: — — and also thank you for the submissions and the recommendations. I am sure the people on the committee will have some questions. I would like to come back to your statistics about the number of beds in New South Wales versus Victoria. You mentioned that the beds are not only for alcohol for also mental health. With the recent Victorian Royal Commission into Mental Health, did you submit anything? Do you expect anything to have come out (indistinct) now the report's been finalised?

MR HICK: Odyssey House did make a submission, but I do not have it with me and I can't talk to that, I am sorry. I can guess what the submission might have been, but I can't tell you. What I can say with our beds is that around about 60 to 65 per cent of the people who come to us will have a co-occurring mental disorder; usually depression and/or anxiety, but around 5 per cent have a serious mental illness, and that is usually schizophrenia. We do not exclude anyone on those grounds. It might take a little bit longer if you're a schizophrenic to come to Circuit Breaker because we've only got 15 beds and we want to limit the amount of people who are there with serious mental problems at any one time, so we can give them the best possible treatment.

Those statistics for New South Wales and Victoria; I can get back to you, if you'd like, and get you a more detailed breakdown of those.

MS VAGHELA: Thanks Andrew for your submission and for your time today. In your submission, you have mentioned that we need to adopt a cautious approach if cannabis use is legalised over here, and then you have given some recommendations. Looking at those two recommendations, one of them is to ban the way we advertise the cannabis sales, and the other one is the packaging of cigarettes. Are we looking at regulating cannabis the way cigarettes were regulated? Is that what the whole purpose is over here?

MR HICK: So, I didn't write that submission. That was from, ah — —

MS VAGHELA: Odyssey House?

MR HICK: Yes, I am part of Odyssey House but what you might call a satellite office of Odyssey House. Now that said, I am a company man and naturally I'd agree with what Odyssey House Victoria has said. Cautiously we might progress towards legalisation; however, having had the experience — I have been working in this field now for 20 odd years or a little bit longer — I think there are a number of pertinent issues. Clearly, this committee has been set up to examine those and I am sure is more than capable of examining, but some of those issues are around the mental health of people, and it seems to me that there are a percentage of people who, if they take cannabis, will be quite severely adversely affected by it.

There is a percentage of people who will not be. Now, that is the same for any drug. It is the same for alcohol. I mean, that is my experience. I was very adversely affected by some drugs; others, you know, not so. It's incumbent on us — how do I put it? I think there are some views that we can have — I do not know about anyone here, but I am talking of myself particularly — as nice, middle-class people, that we can help and we then signal our virtue to other people, one of which is quite popular is saying that we should legalise cannabis.

It's a probably a view I hold myself, but the facts are though, that the people that I associate with outside of work and my family are unlikely to be adversely affected by that decision. However, my opinion is that there is a group of people, who you might want to call the disadvantaged or the people in society who do not have the same privileges I have, who may well be dramatically affected by that. Those would be by concerns. If I can be presumptive enough to advise the committee, (indistinct) speak with those people: the residents, the parents of the residents, those sort of people (indistinct), because you will see from the documents the residents produced, there's a tangled bunch of answers there. There isn't anything specific you could put your finger on and say, 'This is it.' The whole thing is an extraordinarily complex and difficult subject.

If I could add one thing to what they have said, it would be that childhood trauma is certainly a gateway to future drug addiction and alcoholism, and at least 90 per cent of the residents who come through to us will have had some form of childhood trauma, whether that is sexual or physical, or they're abandoned or they didn't get the love that they needed at the time that (indistinct) or there were other traumatic events happening within the household when they were a child — almost everyone.

We do a regime of psychological testing and feedback during the process of staying at Circuit Breaker, and if you (indistinct) in the feedback, we have a psychologist who comes in — as I have often done hundreds of times, I guess. The story's always the same — well, there's always an exception to the rule, but it is childhood trauma, usually generational. It is 'I swore I would never be like my dad, and yet here I am.' In between those two or three things, there is a series of tragic and difficult and traumatic and horrible events that each person has gone through, and I went through. It is no fun; it is really a dreadful, horrible existence being a drug addict or an alcoholic or however you choose to describe yourself.

MS MAXWELL: Thank you, Andrew. I have to say it is a great facility out at Molyullah. I have visited and you have a great compost bin too — they really do. It is that entire farming — —

MR HICK: We have a system for everything.

MS MAXWELL: Yes, there's no wastage, it is great.

MR HICK: That is right. There is a system for how to feed the cat, to a system to when to turn the compost heap over.

MS MAXWELL: But with that comes, I think, the learnings of responsibility, et cetera. Andrew, is it still required that you're actually detoxed prior to going out to Molyullah?

MR HICK: Yes. We are 42 kilometres from the nearest accident and emergency areas. The process of detox can be inherently dangerous, and the last thing we want is for someone to become very ill and us not to be able to treat them quickly. That said, there are people who have fooled their GP and everyone else around them. Drug addicts and alcoholics are particularly adept at manipulating those around them. They turn up and it turns out they are still detoxing.

MS MAXWELL: Would it be advantageous for Molyullah to actually have hospital beds that could assist with the detox, because I know that we do not have enough of that in many rural and regional areas? Would that be beneficial?

MR HICK: Yes, yes it would. It would, if there were particular beds set aside at the local hospital. I think Wangaratta would be the ideal spot. That said, there are any number of ways of people coming to Circuit Breaker. I think it is in human nature to add complexity to things and we have tried to simplify the way people come to us. We've simplified the assessment (indistinct). We say we do not care how you get a detox. We do not tell you that you have to go to hospital or you have to go to a detox down in Melbourne or at Bendigo, but you have to arrive with a letter saying that has happened.

The more the better. As I said, at the moment we've got 82 people on the waiting list and the majority of those are from the North East, a few are from Melbourne and the others are from rural Victoria, and that tells you all you need to know. That waiting list has been there, at pretty much that number, for eleven or 12 years.

MS CROZIER: Thank you so much for your very candid evidence that you've provided to the committee this afternoon and being so forthright in your commitment in what you do. I was actually just going to ask you about that list. You said 82 people; how many weeks is that? What does that mean for people?

MR HICK: That will differ for different people. We try and prioritise some people. If you're pregnant, we will want to see if we can get you in quickly. If you've been through the program before — we try and not have a client/organisation or a doctor/patient relationship — you become part of the family, and we want to facilitate you coming in a little bit quicker if we can.

If you're from the North East, you will get in much quicker than if you're from Melbourne. As a rough idea, if you rang today, we would say, 'Listen, it is probably going to be three or four months before you get in, but all of the planets may align for you and you can get in much quicker, or the planets may not align and it will take you a lot longer.' But, it's, you know, 12, 16 weeks. My experience is that there's a window of opportunity that opens up — usually there's a crisis that has proceeded the telephone call to us. It could be legal or family or whatever it may be. After 12 weeks, often that crisis — I mean, we all have them in our own lives — will abate eventually of its own accord.

Unless you still have that motivation or the crisis persists, then you're less likely to come in. Ideally, you know, we'd be looking at a month or, you know, three or 4 weeks (indistinct).

MS CROZIER: Just very quickly, these statements from your residents, I think are very helpful. As you say, they're varied, but they do talk about specifically what this inquiry's looking at. It is incredibly helpful for the committee to have these powerful statements of around peoples' experience with cannabis, so thank you very much for using that initiative — —

MR HICK: I'll pass that onto them, too.

MS CROZIER: Would you?

MR HICK: Of course.

MS CROZIER: I think it is very, very helpful. So out of that, I am concerned about the mental health impacts of cannabis use, which some of these residents have explained very clearly from their own personal experience, and as you said, it is often the more vulnerable within our community who are going to be caught up with this, because of the complexities that they might face, rather than, as you described, comfortable, middle-class individuals who won't have those same degrees of complexity. I am just wondering: out of those residents that you do see, is it weighted towards the more complex, or do you have some from that more middle-class program?

MR HICK: Yes, both, for sure. We've had police officers and nurses and occupational therapists and social workers and all sorts of professional people, and farmers and so on and so forth. We've had a lot of people through.

MS CROZIER: Proportionately?

MR HICK: Proportionately — this is an anecdote but you would be looking at around about one in 10 to one in 15, I would say, would be from that background.

MS CROZIER: Thank you.

MR HICK: Most people would be from a working class background or a background of unemployment. That is changing as we go along. I do not know about anyone else here, but 30 years ago smoking a joint at a barbeque might not have been an unusual event. In the same way, I think now it's the use of ice at social gatherings. It is certainly in gyms and sports footy clubs and those sort of thing. But I hear this second-hand that is not my scene anymore, as you might have guessed, but I hear that that kind of use is increasing.

MS CROZIER: I think we all hear that.

MR HICK: Yeah. The people who come to us though, as a rule, would be some of the most disadvantaged and discriminated against people in Victoria. They are discriminated against in direct and subtle ways. One of the examples might be the objections to the planning process we are going through at the moment. If we were an oncology hospital, I do not think we'd have the same objections. If you live in a small town, everyone knows your business and it is very difficult to rise above that unkindness, would be a way to put it.

That said, we've got hundreds of people that we know of who are go to Benalla or Wangaratta or Shepparton, order a coffee; and chances are (indistinct) someone who's in our program is going to make the coffee for you, or you go and see the OT, or you go to Woolworth's or whatever it is, and you're going to meet people who have been through our program. I mean, that is partly why I said what I said at the beginning of my submission, that it is just a shame you can't have 'Local drunk makes good,' on the front of the *Benalla Ensign*, because there is that stigma and discrimination, and you do need to protect your own privacy around those issues.

If you had a broken arm or you'd hurt yourself in a car crash, people would be sympathetic, but it doesn't quite work out that way. Adding to that, there often seems to me to be a sort of class component to that. We look at people from a particular class and that is what we'd expect from them anyway, and yet what we see at Circuit Breaker is people producing documents. No one in the program, as far as I know, would have produced a document like that. You give them boundaries and the ideas around it and, 100 per cent, these people are just like we are, but they've had a far more difficult life.

We see people aspiring and achieving all the time and doing fantastic, marvellous things and I know I sound like a do-gooder, but you know, I am still, after all of these years, genuinely pleased and inspired to be working with the people that I work with.

MS WATT: Hello Andrew, thank you so much for talking to us today. I haven't visited your centre but indeed have visited Aboriginal community-controlled services near Shepparton. The question that I had for you is do the residents in the program have access to justice professionals or legal professionals whilst participating? Are there those sorts of connections between what you do and the legal community? I am sort of exploring the health/justice model and if you're indeed part of it with your program.

MR HICK: Sometimes a legal issue will arise during the program, and we will then arrange for them to see solicitors and so on and so forth. Sometimes they will need to be arrested and charged whilst they're in the program, and the police find out where they are. We've got a good relationship with the local police so we will take them into town, and we will have a discussion with the police. We've never had them turn up and drag someone off thankfully, and we've always had people bailed back to us. People will also have conversations with their legal advisors, but what we try and do is have any proceedings or hearings, if it is at all possible, delayed until they've finished their treatment.

That gives them a fair (indistinct) I am sure — but why not. It gives them a much fairer chance when they're in front of the magistrate or the court if they finally end up there. And I have known down at Lower Plenty, judges to put off cases for 18 months until someone's completed the program and got their driving licence back and done this and arranged that apprenticeship and so on and so forth, which seems to me to be a very wise way of going about it.

MR LIMBRICK: Thank you for appearing today. The submission states that the majority of cannabis users do not have problematic use, but clearly some do have problematic use. What do you think is the thing that causes some people to not have these problems and then some people to progress into it? I think you mentioned issues with trauma and things like this before; I'd be interested in your views on that.

MR HICK: In those circumstances, the question is why someone is taking it in the first place. If you're at university and it is all fun and everyone's having a laugh and this is what your peer group are doing, then that is a very different matter. I know I have used my experience in my life to trying a drug or a drink — I suppose I was about 12, and using that drug and feeling, for the first time in my life that I was like other people, and that thank God there is something in this world that stops me feeling like I was feeling 30 minutes beforehand. I use myself as an example; I must have had hundreds of conversations with people, talking about exactly the same experience, thousands I suspect. It felt great for me, and it felt great for them. That is probably not a good way to start the relationship with a drug, feeling that it is your saviour and that instead of it being like this is social

thing and this is fun. One of the things I noticed in the document that the residents produced was that almost uniformly they talked about smoking cannabis alone and doing drugs alone.

I can't speak for them particularly, but I would assume that what they're talking about there is kind of the self-medication. If you start using drugs or alcohol and it is a relief and think thank goodness this thing exists, then it doesn't speak well for the rest of your relationship with that drugs. I am remembering a conversation I had with a chap years and years ago, and he was talking about — I won't talk about which drug it was, but he was talking about the drug he had, and he was saying, 'I took this for so and so amount of years,' and I interrupted him and I said, 'And it nearly killed you,' and he said, 'No, no, you've got it all wrong, you do not understand it; it saved me. That drug saved me. If I hadn't have taken that drug, I would have killed myself.' And I understand quite well from my own experience — although it wasn't as extreme as that — what he meant by that, which was that if you do live that life of abandonment and brutality and sexual assault and not getting the love that you want, then boy, why wouldn't you take something that makes you feel happy and gives you some relief from what's been happening in your life for the last however many years that that might be? It is a conversation that in my experience occurs all the time in the treatment experience for our residents.

Now, I felt as if I was the same (indistinct) for the first time. And then as you come to appreciate that, you are always trying to recapture that. We captured that direct feeling that you can stop yourself feeling bad, if that is if that is what's happening for you.

There is another aspect too, in that, if you've been rejected by your parents, by school, by social groups, then that sub-culture, that drug assault type culture is unlikely to reject you. And we all want to belong somewhere. We are human beings and that is our (indistinct) instinct to belong to the group. It's probably not a healthy group to belong to and we talk long and hard about that with our residents, but it is unlikely to reject you like everyone else has rejected you.

MR LIMBRICK: Yes, thank you so much.

The CHAIR: Yes, thank you - thank you Andrew and we've yet again gone over time, because it is been an absolutely fascinating discussion (indistinct). I think it is really important and the contributions for your residents have been really important to this, because it is the contrast and it's Odyssey House is working at that very pointy end. So I note in the submission, we know that cannabis use accounts for 0.2 per cent of the disease burden nationally in Australia. it is generally speaking, it has a very low burden on our society. However, for some people it has provided that answer, and that moves — —

MR HICK: They're yes and a lot of them. I am going to apologise to the committee, my answers haven't been specifically around cannabis.

The CHAIR: No, that is fine.

MR HICK: It is really around my experience and dealing with the people who come through to us. But, yes, it is all part of that tangled sort of knot that you guys have to untangle.

The CHAIR: And I know. It happens to us in every committee that we've done probably this year, that you know, the disadvantage, childhood trauma and all of those issues are almost — we can have a conversation about decriminalising cannabis, but for those that are experiencing childhood trauma, it won't matter whether we decriminalise cannabis or not. That won't change the path that they may travel. And, certainly the prohibition hasn't stopped anyone from probably accessing cannabis.

MR HICK: No, I wouldn't have thought so. I mean, look, there might be an argument that if it is more available, then more people will take it. But I think that is beyond my agreement; I can't comment on that really.

MS MAXWELL: Do we know if there's publicly any data available, those who are using cannabis and then — because you say here at 0.2 that the actual effects on family members that bigger domino effect of how many people are affected by that usage. Have you uncovered any data — —

The CHAIR: I think when we've looked at the effects of drug use, generally cannabis doesn't really get a mention in there.

MS MAXWELL: Okay.

The CHAIR: Alcohol, definitely, and then other more serious drugs.

MS MAXWELL: Yes.

The CHAIR: And I think when you look at those drug harm graphs, they take into account the harm on society, the harm on family, the harm on the individual. And in fact, there's one I have seen that has got different colours in each of the columns, and yes, at the pointy end, it is a very different thing. Andrew thank you so much for all your work.

MR HICK: Pleasure. And I hope that it is been helpful.

The CHAIR: And please - yes. As Georgie said please pass on our gratitude to the residents for taking the time to consider this.

MR HICK: I will do and if any of you would like to come and visit us at Circuit Breaker, at any time, please give us a call, you'd be more than welcome.

The CHAIR: Thank you. Thank you.

Dr KIEU: Thank you very much Andrew.

MR HICK: Thanks.

MS MAXWELL: Yes, thank you.

MS CROZIER: Thank you. Thank you very much Andrew.

Committee adjourned.