

OUTLINE OF A GROG AND DRUGS (and therefore VIOLENCE) STRATEGY

A very great proportion of the violence in our communities is associated with grog – the court convictions and clinic records show this clearly. If we get on top of our grog and drug problem, we will get on top of the worst of our violence problem¹. It is clear that strategies to combat violence will not get very far if they are not primarily aimed at our grog and drug problem.

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¹ Anthropologists will point out, perhaps tendentiously, that violence was part of traditional society, and that our understanding of the contemporary problems needs to take into account what Peter Sutton calls "the legacy of a formerly and in some places very recently stateless society and its perfectly expectable system of self-help or self-redress during conflict, including frequent recourse to physical means". This is true, but it is plainly productive of confusion to place too much emphasis on this point in the face of the kind and degree of violence we experience today. The evidence is very clear that the growth of the grog (and now drug) epidemic has radically altered the context and nature of violence from the old days. Therefore, whilst we should not be blind to Peter Sutton's point, we should also not be blinded to or confused about *the direct connection* between grog and the terrible violence amongst our people, and the fact that if we solve our grog problem, we will get on top of the worst of our violence problem.

INTRODUCTION

It is necessary for us to gain an understanding of the grog and drug problem in Aboriginal society in Cape York Peninsula. For too long the thinking that has been floating around and the "strategies" and "interventions" have not made much sense. For example, how do we pursue a policy of "normalising" drinking when so many of our people are alcoholics? In fact we currently have government sponsored programs where it is difficult to get a clear idea what people are actually trying to do with the problems: there's no strategy, no clear thinking.

The Aboriginal-specific literature produced by academics and researchers has not assisted me in gaining any understanding. This literature has mostly misunderstood the nature of substance abuse as social epidemics, and has mostly created and compounded confusion.

The analysis of the grog and drug problem presented here, as well as being based on my own experiences and observations in Cape York and on illuminating discussions with many Aboriginal people from the region over the years, proceeds from key insights set out in two main sources.

Firstly, it was the late Mervyn Gibson from Hope Vale who first talked to me in the mid-1980s about the way drinking had become embedded in our Aboriginal social relations and ideology (it had *insinuated* itself into our culture) and we collaborated in a paper Mervyn presented to the ANZAAS Conference in Townsville in 1987².

Secondly, the analysis of substance abuse epidemics by Nils Bejerot³ underlined to me that the key features of substance abuse epidemics in our Aboriginal society were no different to their occurrence in other human societies. Yes, cultural circumstances and responses may be specific to a particular society, but we must always keep in mind the way substance abuse epidemics adjust to particular cultural and social contexts and start to manipulate the culture and social relations towards the service of addiction. Whilst our native culture may have been particularly *susceptible* to the substance abuse epidemics that are now overwhelming us, we must understand that our native culture and social relations were not subjected to the *abuse* and *manipulation* that are intrinsic to substance abuse epidemics.

This analysis and the strategies that are suggested as arising from it are hard on the problem of grog and drugs in our society. But we must not be mistaken: we have to confront the problem as matters of behaviour and responsibility. I have no doubt that the implementation of a strategy based on this *Outline* will be emotionally and socially difficult for us and our people.

² Merv Gibson *Anthropology and Tradition: A Contemporary Aboriginal Viewpoint*, ANZAAS Conference, unpublished, 1987.

³ Nils Bejerot *Addiction: an artificially induced drive* Springfield, Ill., Thomas Books 1972, Nils Bejerot *Addiction and society* Springfield, Ill., Thomas Books 1970.

It is a standard "progressive" parroted phrase that one should be tough on the *reasons* for drug abuse, violence and so on and not condemn people. But there are no abstract "problems" that can be made responsible instead of our own lack of insight, responsibility and action. And I'm not only, or even mainly, criticising the established addicts. The non-addicts must confront the addicts and make it more uncomfortable in every way for them to continue leading their abusive lives than to stop, otherwise we are *condemned as a people*. There is no court of appeal presiding over world history where we can appeal our disappearance as a people and the disappearance of our distinct cultures on the grounds that past and present suffering made us unable to adopt the right policies when confronted with a life-or-death dilemma.

We must always keep in mind that it is in the nature of addiction problems for social and emotional barriers to be raised up against any attempt to confront the problems. We cannot continue to avoid the problems because it is too "culturally" confronting.

This is not a matter of blame...but it is a matter of responsibility

Of course most Aboriginal people we know in the Peninsula – our cousins, our friends, our uncles, our brothers – who are involved in the pathologies of drinking and gambling, are caught in an economic and social system not of their choosing. They do not set out to create misery for their people. They do not set out to destroy the prospects of their children. The suction hole of these drinking and gambling coteries, and all of the social and cultural pressure that it brings to bear on people is almost impossible to avoid. Even where people remain sober their resources are drawn upon by these activities. People who manage to get over grog and try to set out in a new direction after spending time in prison end up being sucked back.

This is not a matter of blame. People are caught in an economic and social system which precipitated this misery. But it is a matter of responsibility. Our people as individuals must face their responsibility for the state of our society – for respect and upholding our true values and relationships. Our own laws and customs.⁴

⁴ Noel Pearson *Our Right to Take Responsibility*, Noel Pearson and Associates Pty Ltd, Cairns 2000, p.19.

1. UNDERSTANDING THE PROBLEM

1.1 The symptom theory is wrong

- susceptibility factors must be distinguished from causal factors
- it is the existence of the epidemic rather than personal factors that is decisive to recruitment to addiction
- we must understand the difference between prevalence (the number of active abusers) and incidence (the number of new cases in a certain period of time)

Our worst mistake is that we have not understood the nature of substance abuse. I maintain a fundamental objection to the prevailing analysis of substance abuse amongst our people. The prevailing analysis is that substance abuse and addiction is a *symptom* of underlying social and personal problems. According to the symptom theory we must help people deal with the reasons that have seen them become addicted to various substances. According to this theory we must address the "underlying issues" if we are to abolish substance abuse. The severe substance abuse in Aboriginal communities is said to have been caused by immense ingrained trauma, trans-generational grief, racism, dispossession, unemployment, poverty et cetera.

But the symptom theory of substance abuse is wrong. Addiction is a condition in its own right, not a symptom. Substance abuse is a psychosocially contagious epidemic and not a simple indicator or function of the level of social and personal problems in a community. Five factors are needed for an outbreak of substance abuse: (i) cash (ii) spare time (iii) the substance being available (iv) the example of others and (v) a permissive social ideology. Under these circumstances substance abuse can spread rapidly among very successful people as well as marginalised people.

Of course substance abuse originally got a foothold in our communities because many people were bruised by history and likely to break social norms. The grog and drug epidemics could break out because personal background and underlying factors made people *susceptible* to trying addictive substances. But when a young person (or an older non-addict) is recruited to the grog and drug coterie today the decisive factor is the existence of these epidemics themselves, not his or her personal background. And for those who did begin using an addictive substance as an escape from a shattered life and from our history, treating those original causes will do little (if indeed you can do anything about those original causes). The addiction is *in itself* a much stronger force than any variation in the circumstances of the addict.

There are two insights here that I want to reiterate in order to make the theoretical foundation of my proposed strategy crystal clear. First, at this advanced stage of the grog and drug epidemics it is not a breach of social norms to begin with

substance abuse. It follows that we cannot *divert* young people away from substance abuse. No matter how much money and effort we spend on alternative activities, drug free activities can *never* compete with the more exciting drug-induced experiences for young people's attention, because all hesitation about the appropriateness of an abusive lifestyle is long since gone. Good living conditions and meaningful activities might, under normal circumstances, make non-addicts less *susceptible* to trying drugs and thus help in *preventing* outbreaks of substance abuse epidemics. Diversionary measures can only *prevent* substance abuse epidemics, not *cure* them once they are underway. Second, even under optimal circumstances, life is difficult and full of conflict. No matter what we do, we can *never* make life so good that an addict voluntarily leaves her or his antisocial lifestyle and joins us in our struggle for a better future. The addict has already shown that he or she loves the effects of the substance abuse more than his or her own land, people, family and children. We can never convince an addict to quit by offering a materially and socially better life including land rights, infrastructure, work, education, loving care, voluntary rehabilitation and so on. The addict will just use all these material and human resources to facilitate an abusive lifestyle.

It is understandable that the symptom theory thinking is so widespread. Desperate people are often abusers. But many poor environments are not immersed in addictive substances and many rich environments are. I repeat, we must understand that trauma, dispossession et cetera make our communities *susceptible* to grog and drug epidemics, they do not automatically *cause* abusive behaviour. Of course a high number of people who are susceptible to turning to different kinds of abuse are, in an indirect way, a causal factor that might contribute to an outbreak of a substance abuse epidemic. But, I repeat for the third time, this fact has led to two fatal logical errors in our efforts to understand the current social disaster. Addiction is a condition in its own right and it is just as difficult to do anything about an addiction if you are a socially and economically strong white professional that became addicted through careless drinking of exquisite wines, as if you are an unemployed member of a decimated and dispossessed Aboriginal tribe. We must understand that an established addiction is a very strong force at the heart of the will of the addict and independent of the historical causes of the first voluntary consumption of the addictive substance, which might be as banal as using a legal drug to relieve a temporary pain. Regrettable circumstances and things that we and others did in the past (and who doesn't carry a burden of things that we wish were different?) are perhaps important to consider in the rehabilitation of an abstaining addict. But trying to undo the past and to solve present difficulties such as unemployment has no impact on an active substance abuser's addiction and lifestyle; the addiction and the consumption must be confronted head on and immediately. We do not need to improve everything that is bad and unjust before we can hope to get rid of substance abuse. What we need in order to get rid of grog and drugs is a theoretical understanding and a new social ideology.

"Progressive" people will now say that Noel Pearson is giving the Federal and State governments an excuse to cut spending (or avoid increasing spending) on programs that address "Aboriginal disadvantage". But I have never disputed the governments' responsibility to provide funds, and this is not what I'm discussing anyway. I merely observe that the programs that have been proposed in order to improve the living conditions for indigenous Australians will have little or no impact on the substance abuse epidemics. Furthermore, the proposed programs will not achieve what they are intended to achieve (better infrastructure and health, less violence and so on) if there is no realistic plan for curing the substance abuse epidemics that are currently in place.

More surprising than our (understandable and excusable) mistaken view that a troubled person's historical legacy maintains the addiction and must be dealt with if the abusive behaviour is to cease, is our blindness to the fact that today, when strong people who have struggled to take responsibility for our families and communities, and young, healthy, not traumatised people with their lives ahead of them, get sucked into the most foolish and destructive behaviours imaginable, history is irrelevant not only in the treatment of the addiction, but also increasingly irrelevant as an explanation for the first experimenting with addictive substances. When abusive behaviour is deeply entrenched in our communities it is not the material destitution, the social ills and historical legacy that fuel the abuse epidemics. *It is the epidemics that perpetuate themselves.*

And these epidemics cannot be cured with our current policies, which are based on voluntary rehabilitation. An addict may be willing to deal with the addiction after many years of abuse, when the social, medical and economic problems become annoying. In fact this is the usual pattern of people "giving up grog" in our communities. After a health scare and a "last warning" from a doctor, a middle-aged drinker will stop drinking. But by this time he or she is likely to have ruined his or her health irreparably and in any case, will have wreaked a lot of damage in his or her community prior to giving up, by making life miserable for family and community members, and by recruiting more people to addiction.

This last point is an important insight. It is mainly during the first part of his or her career that an addict spreads the abusive behaviour, not when he or she has become a social invalid. There is a whole literature about how addicts have been helped after decades of abuse. It is of course good if people manage to stop abusive behaviour, but if our policies are restricted to offering help to addicts we will get nowhere. We might reduce the prevalence (the number of active abusers) marginally but not the incidence (the number of new cases in a certain period of time). And if we are unable to reduce the incidence because we have no efficient methods for influencing the behaviour of the addicts that are spreading the abuse, and the people just about to be recruited, we will not curb the epidemics.

Put it this way: today people begin abusing grog and drugs in our communities because other people do. And if "underlying issues" make somebody start

drinking or using drugs, the most important "underlying issue" today is the chaos caused by the grog and drug epidemics. And addiction is not a symptom of bad or chaotic circumstances anyway; removing them will not cure addiction, and hence not stop abusive behaviour.

This analysis is of course a simplification; our history and our exclusion from mainstream society have not become irrelevant factors. But these generalisations are more valid than the symptom theory. We must understand, and learn to recognise, the symptom theory. It is probably one of the most destructive ideas affecting Aboriginal policy generally, and grog and drug policy in particular. Its most evil effect is *to promote passivity* in the face of a social disaster: "it is difficult to do anything about the addiction problems because they are just symptoms of underlying problems (that are impossible to solve)". The symptom theory is based on an incorrect understanding of addiction epidemics and therefore causes confusion in relation to how substance abuse should be tackled.⁵

1.2 **Addiction is a learnt behaviour that makes us powerless**

- substance abuse is related to behaviours such as gambling
- abuse epidemics make us politically and socially powerless, they are not primarily a "health problem"

Substance abuse belongs to a much wider range of *learnt behaviours*, which have in common that they immediately trigger rewards ("highs") which may or may not be induced by substances foreign to the human body. The reward of abusive behaviour is instant and in the psychology of the addict linked to the consumption of the substance or other high-inducing act, but negative consequences come later and are therefore not linked to the abusive behaviour. People's behaviour is determined by this simple conditioning: they have learnt to associate wellbeing, or absence of discomfort, with taking the "drug" (which may be immaterial), but emotionally no connection is made between the (later) negative consequences (psychological, medical, social, economic and so on) and taking the "drug". The suffering is not psychologically linked to the abusive behaviour, but the reward is. The addict is therefore willing to tolerate great misery but won't kick his habit. Intellectually of course it is easy to realise that there is a causal connection between the drug and the problems, but intellectual insight is no match for the deeply rooted conditioning. Intellectual understanding is a very thin layer on top of what we share with animals. Once we are addicted, it doesn't matter that the punishment becomes disproportionately large relative to the reward. The solution to this paradox is, as I said, the difference in how strongly reward and punishment is psychologically linked to consuming the drug or other abusive act.

Abuse epidemics make us powerless

⁵ Edited and extended extract from "Strong Families, Then Strong Communities", paper presented to the Roundtable convened by Senators Herron and Newman, Old Parliament House, 24 October 2000 (the *Indigenous Roundtable* paper).

People who talk about abuse of different kinds usually see it as a health problem (if they are "progressive") or a moral problem (if they are religious and/or conservative). But abuse epidemics are a *political* question. The social function of addictions is to make people unable to organise themselves, politically and socially. It is true as the drug liberals say that many of the negative consequences of illicit drug use (criminality, overdoses and so on) are due to the fact that the substances will be expensive and of varying quality as long as they are illicit. It would be perfectly possible to make everything you can get addicted to readily available, that is add the presently illicit drugs to the endemic abuse of alcohol, nicotine, gambling and so on, give up all attempts to control the endemic abuses, and still have a functional society. From an apolitical or irresponsibly liberalistic viewpoint, "harm minimisation" through permissiveness would probably work (but my people would probably have disappeared before the situation stabilised). Talking about one particular addictive substance, Paul Dillon from The National Drug and Alcohol Research Centre might be right that "it's still a very small proportion of people who are going to use heroin no matter how available it becomes"⁶ or he might be wrong. But I have seen to my surprise and horror how large groups of "normal", functional people who took responsibility for families and originally were very distant from abusive behaviour, were sucked into the alcohol abuse epidemic when it gained momentum in my hometown of Hope Vale, and in other communities in Cape York: not even grandmothers have withstood the force of these epidemics. And it is also obvious that the political consequence of more permissiveness would be that the remaining non-abusers' energies would be consumed by dealing with yet more distractions on top of the problems we already struggle with. Of course much of our energy is already consumed by the consequences of the unnecessary addictions in our society, but if we let the "progressives" and the libertarians win now and make harm minimisation the main social response to substance abuse, the change into a drug society would be irreversible. And our people, on the very bottom of stratified society, can least afford this policy. It is therefore a *political* struggle to prevent the final establishment of new abuse epidemics, and to limit by means of restrictions the damage done by the endemic addictions of Australian society, which we have adopted, such as alcohol and gambling.

1.3 Five factors involved in the outbreak of substance abuse epidemics

- availability of addictive substance
- spare time
- money
- the example of others in the immediate environment
- a permissive social standard and ideology

The strength and importance of social standards

There is of course a close connection between the last two factors: the example of others in the immediate environment and a permissive social standard and ideology.

⁶ Sydney Morning Herald, 10 May 1999

We should not underestimate the strength of social standards and ideology, and I give the example of card gambling at Hope Vale. Whilst the social standards at Hope Vale today have collapsed in relation to grog and now drugs, there is a curious relic of the social standards that used to prevail in the old mission reserve days: the prohibition against card gambling. It is true that today a large number of Hope Vale people engage in betting at the TAB in Cooktown, and participate in card gambling in other places (Cooktown or Wujal Wujal), but the social standard against card gambling within Hope Vale has survived – notwithstanding the collapse of other standards. The original social standard was a combination of official prohibition and enforcement (Community Councils and Community Police enforced the standard set under community by-laws) as well as social ideology. (In fact it may be that the strength of the prohibition against card gambling is related to the cultural/religious influence of the Lutheran Church at Hope Vale). Official enforcement is only part of the strength of social standards like a social prohibition on card gambling – standards become embedded in the social ideology of the community and are very powerful: either for good or for bad.

Social standards in relation to alcohol

It is worth remembering that in societies that have lived with and managed alcohol for a long time that as well as formal laws governing its sale, consumption and associated behaviours, there are numerous informal standards and ‘conventions’ that are integral to the social function and control of alcohol. These social standards dealing with the times and occasions for drinking, the types of alcohol, the quantities consumed et cetera are part of the culture and form the habits surrounding the consumption of alcohol in societies that have learned to ‘live with alcohol’. These standards operate to control the potential effects of an addictive substance in society. Various societies ‘live’ with alcohol with varying degrees of success, for the descent from pleasurable use to dependency is inherently difficult to control. Even for white-fellas in Australia the use of alcohol comes at a major social and health cost.

Of course in our society in Cape York, as with indigenes across the globe for whom alcohol was a novel drug, we have not mastered the use of alcohol and indeed it has been a complete disaster. And the circumstances in which we ‘learned to drink’ explains why we have adopted the worst possible social standards and habits of consumption – habits guaranteed to lead to widespread alcoholism. The history of supplying poor quality grog out of the backdoor to Aboriginal people who were not allowed into pubs and who would have to consume their grog in the shadows, in the bush, down at the park – was an inauspicious introduction to the use of alcohol by our people.

And the way in which we use alcohol today is no better. Even when we are not consuming grog in the parks or in ‘the long grass’, our socialising around grog – in our homes, at local football matches, around the barbeques et cetera – involve massive quantities that are consumed in one bingeing session. The white-fellas with whom we drink or whom we emulate in our drinking habits have themselves very little or no control over the use of alcohol. Too many of the white-fellas who socialise with us, and who set an immediate example for us, are hopeless drunks – it is little wonder that our

consumption of alcohol has never been subject to the social standards and conventions that militate against its abuse.

Looking at the history of our descent into the grog and drug epidemic against these five factors underpinning addiction epidemics

It is not possible to present here a detailed history⁷ of the grog problem that arose in Cape York over the course of the past 30 years⁸ (and the illicit drug problem which has grown over the past 10-15 years). The historical experience of each community in the region is different, but there are strong parallels and common features in these histories. Consider for example how the social standards in relation to grog have changed in recent times:

- Unacceptable – this was the social standard during the mission days, and in the days before canteen
- Neutral – "it's up to each individual to decide for themselves", "we can't do anything about it anyway, it's up to them"
- Desirable – this is where we are at. The social standard is not just neutral; there is in fact very strong social and cultural pressure to drink, and high social and cultural value in drinking.

Such an historical survey would need to widen the perspective from the communities to the wider Australian society. For example, an ideological defeat of historic proportions is that "progressive" or "liberal" movements during the last half century generally have been permissive in relation to drugs and grog, which has increased social confusion and made people less able to organise themselves socially and politically. To what end and in whose interest? One would also need to look at the establishment of the passive welfare paradigm and its staunch (and deliberate) defence, which has crucially affected several of the factors involved in the outbreak of substance abuse epidemics.

⁷ However each community in Cape York should come to an understanding of the history of the grog and drug problem amongst their people.

⁸ Of course, the kind of social devastation that we have experienced over the past 30 years with the earlier growth of the grog epidemic (and the later and ongoing growth of the drug epidemic), has precedent in the colonial era. The social devastation on the frontiers and on the fringes of colonial settlement also involved alcohol and opium (ashes mixed with water and then drunk) – and it was this devastation that gave rise to the 'protection' measures that resulted in the creation of missions and Aboriginal Reserves, where access to grog and opium and relations with the wider white community were prohibited. In these (highly problematic) institutions where there was simply *no availability of addictive substances*, the survivors of the near genocide of the frontier years (the Cape Bedford Mission that became Hope Vale is one example), grew up and rebuilt families out of the diaspora. This situation of institutionalisation and rebuilding lasted variously from the last decades of the 19th century up until the 1970s. Along with diaspora communities like Hope Vale, peoples who were not significantly affected by the colonial process and who were not dispossessed of their lands (the Aurukun Mission is one example) were also institutionalised. The nature of the social devastation with which we are concerned today are common to all of these one-time institutions (and now "communities"): no matter the different colonial experiences of the various communities and the different degrees to which they retained their "classical" traditional cultures. Hope Vale is no different to Aurukun in terms of the social problems that have become prevalent in both communities, and for that matter they are not a great deal different to communities in western New South Wales or Arnhem Land today.

1.4 Grog and drug addiction is a psychosocial epidemic in our communities

The problem is not just individual, it is social – so the solution cannot be just individual, it must be social

I hear many Aboriginal people who are worried about the grog problem discuss solutions to the problem as matters of individual choice; that it is up to the individual to decide to give up and reform his behaviour. The individual is supposed to make this decision to reform him or herself whilst the social vortex of the grog epidemic is still raging in his or her village. It may be that the lesson learned from AA – that the individual must confront and admit to his or her own addiction and make a decision on it – is the source of this emphasis on the solution being one of individual choice.

You hear people say:

"...it's up to him...he's got to decide for himself"

"...it's up to the individual, we can't force him..."

"Noel, I want you to have a talk to your cousin. Warra, he's just too far gone. Talk some sense into him. He's got to stop drinking."

But I am thinking that my cousin is caught up in a social web that includes his cousins and mates – that will make it near impossible for him to deal with his problem. It is clear that the problem is social. Surely the solution must also be social. (But I do not doubt that individual confrontation with his or her problem must be a necessary part of the social strategy).

The epidemic is embedded in our Aboriginal social web (mates, relations, countrymen) and has become our new dysfunctional culture (to drink is to be Aboriginal).

When you look at a drinking circle you see people who are socialising around grog. Social and cultural relationships between the drinkers are expressed, reinforced and reiterated whilst people are engaged in drinking. Everyone involved in the drinking is obliged to contribute resources – money – for the purchase of grog. Everyone is obliged to share the money and the grog.

These social and cultural obligations are invoked at every turn by members of the drinking circle. These invocations are very heavy indeed and they most often draw upon real obligations and relationships under Aboriginal laws and customs. What – when people are not drinking but hunting – is a cultural obligation to share food with countrymen, is turned into a cultural obligation to share grog. In fact your fellow drinkers will challenge your Aboriginal identity in order to establish your obligation to contribute money to buy grog: "Come on, don't be flash! We not white fellas! You-me black people!"

When you look at the obligations which are set up around the drinking circle, you see the drinkers under reciprocal obligations to contribute to buying the grog. When I have money it's my turn to shout. When your money comes, it's your turn to shout. Outside of this drinking circle are the women and the children and old people and the non-drinkers. The resources of these non-drinkers are used to feed the families – including those who have spent most or all of their money on grog, when they are hungry. But more than that, these non-drinkers are placed under tremendous social and cultural pressure to contribute resources to the drinking circle for buying grog. So the drinking circle becomes the suction hole for the family's resources. Wives and girlfriends, parents and grandparents, are placed under tremendous pressure – social and cultural and ultimately through physical violence: "Why you wanna stop me from having fun with my brothers?" – to contribute to these pathological behaviours.⁹

Addiction creates clever and determined defence advocates.

"We got the right to drink...we got the freedom to drink in 1967...and we not going back to the Jacky Jacky days..."

"You tryna be flash...you think you stuck up like a wangarr...your arse is as black as mine..."

"You see, us parkies are the real murriss...you big shots denying your relations...what you shame for black fellas?"

"We need spirits available in the canteen...that's the only way people gonna learn to drink properly"

"We need a 10 to 10 pub...then people will drink properly"

We all know that addicts, inspired by the symptom theory, talk about the things that must become better before they can quit, and about the bad circumstances that once made them begin with substance abuse. They talk about a certain substance not being so bad ("surely it's better if people smoke dope than sniff petrol"), they talk about a problem being marginal and not threatening to become widespread ("too early to do something"), about the battle being lost ("too late to do something"), they talk about themselves being an exception ("in control") et cetera. They will come up with any argument that relieves them of responsibility for their abuse.

1.5 Almost all of our other social and health problems are derivative of our grog and drug problem: we solve grog and drugs, we will solve everything else

- "harm reduction", "clinical care", "public education programs – dynamic poster workshops!" "family violence strategies", "school attendance

⁹ Extract from *Our Right to Take Responsibility*, p. 17.

strategies", "life promotion programs" "economic development strategies" – these are all either (i) diversions from what really needs to be tackled or (ii) they are totally futile or (iii) will have only marginal and temporary success as long as we don't confront the grog and drug epidemic amongst our people

Another big mistake has been in our analysis of Aboriginal health. In the prevailing debates, poor health is automatically seen as a product of Aboriginal disadvantage. But our material circumstances have improved greatly at the same time as our life expectancy has decreased.

For people who are not poor and participate in the economy, ill health is only a minor consideration during their first seven or eight decades. Under normal circumstances people will need a few or even no medical treatments for most of their lives and then they die either suddenly and cheaply, or slowly, in which case they will need more expensive care. Aboriginal people should for most of their lives not need health care any more than other Australians. What our people need more urgently than an expansion of the health care system, is an immediate dismantling of the passive welfare paradigm and an end to permissive thinking about grog and drug policy, because it is those factors that generate the endless flow of Aboriginal injuries, neglected children and unnecessarily sick people to the clinics. A medical practitioner I've been corresponding with gave me this explanation for not having read some texts I sent:

I am a little tired at the moment and am not absorbing as much as I would like. Has been busy here as usual and seem to have an ever increasing number of neglected, malnourished children not being cared for by family because they are all in the canteen. That is the worst part for me, seeing the innocent children suffer and the next generation being destroyed.

Aboriginal people don't have health problems that can be solved with medical treatment; they have *passive welfare injuries* inflicted upon them. Of course it is not our modest benefits that make us sick. It is the circumstance that too many of us have an outlook determined by addiction and passive welfare, and consequently behave ruthlessly against other members of our communities, apart from destroying themselves.

What I have just said is deliberately provocative. Much could be achieved within the framework of traditional thinking about Aboriginal health. The ABC reported the following story:

Lack of services blamed for high rate of indigenous heart disease

A new report has found the lack of medical services in remote communities is partly to blame for the high rate of heart disease among Australia's indigenous population. . . While major risk factors, such as

high alcohol use and smoking are to blame, the report highlights the need for more prevention programs. . . "There's a lack of services and there's a real need to build up services for prevention for Aboriginal and Torres Strait Islander people," Professor [Ian] Ring said. The report says the number of deaths from heart disease can be reduced by 40 per cent.¹⁰

The equivalent report in The Age read as follows:

The uncosted and wide-ranging plan includes recommendations to improve living conditions, change health funding structures, train more Aboriginal health workers, make fresh foods more affordable in remote areas and improve access to health services... It recommends a five-year national program to wipe out deaths among Aboriginal children from rheumatic heart disease... Professor Ian Ring said the government could implement the report as "practical reconciliation"¹¹

I do not belittle such efforts. The problem is the lack of strategic leadership and guidance shown by Government in attacking the strategically important, structural faults that generate the never abating waves of damaged Aboriginal people through our health care system. These structural problems are that our people in Cape York are engulfed by passive welfare (which in itself weakens you and makes you less able to benefit from service delivery), at the same time as very many of us are destructive and irrational addicts who disrupt the lives of the non-addicts so that they become almost as difficult to reach with help as the addicts. Who will be functional enough to absorb information, participate in prevention and take responsibility for following medical advice under such circumstances? I travel a lot in rural areas. I see the children with foetal alcohol syndrome. When I wait for the plane at the aerodrome I see things such as beaten young women in wheelchairs waiting to be flown out. There's a limit to what the prevalent policies and suggestions can achieve when there is no understanding of why our behaviour is so disturbed.

Since the Government is not malevolent, their problem must be a lack of analysis and intellectual and political courage. It takes a very different kind of courage to challenge the deeply rooted progressivist and liberalist prejudice of the Australian middle class compared to the courage necessary, for example, to take the guns off angry shooters or to bend the law in order to extinguish Aboriginal people's native title rights held under common law. The talk about "practical reconciliation" will achieve little without understanding the problem, and the "health, housing education" mantra (sometimes "health, housing, employment") achieves just as little in the mouth of a sympathetic conservative or liberal, as it does coming from the progressivists.

¹⁰ ABC, 9 August 2000

¹¹ The Age, 9 August 2000

I do not mean that the recent phenomena of substance abuse epidemics and passive welfare have turned good health into bad. We had health problems before passive welfare too, but they were *poverty injuries*. Now we suffer from passive welfare injuries, but they must be something different, since we are not poor. We have more cash than many healthier and more functional societies. The passive welfare injuries are confusingly similar to and superceded the poverty injuries so that there seems to be a continuity between these two fundamentally different threats.

What we are doing now is that we create the optimal conditions for our addicts who don't want to change, to consume all of our resources and to disrupt our society. What abusive members of our communities experience is not a determined rejection of that behaviour, it is (i) unconditional financial support for nothing (ii) endless nonsense talk to give the impression that something is being done ("prevention", "harm minimisation") (iii) limitless understanding and care when the complications of abusive behaviour become annoying and (iv) ideology production for the defense of abusive lifestyles (the "symptom theory", "inherited trauma").¹²

Notice the commonality in the responses to drug abuse in our society and in the wider society.

The 'progressive' response to illicit 'hard drugs' in the wider community is not at all different to the response of our own community to grog abuse. In other words, rather than a determined rejection, there are white-fella equivalents of the denial and avoidance of confrontation that has characterised all attempts to control the grog and drug epidemics in our communities.

Both communities are confused as to how to deal with the drug epidemics facing them. The cultural details may be different, but the ideology that is generated in our Aboriginal community in the face of abusive behaviour driven by addiction – is not at all different in the wider society. The excuse-making, defensiveness, avoidance of the real issues, bending to the demands of addiction, latching onto cultural traits that might help justify and exacerbate the problems – these are universal responses that have more to do with the nature of substance abuse epidemics than with the specific cultural circumstances of a community. However this is not to say cultural circumstances are not critical to understanding the way in which substance abuse takes hold in a community: I believe that our Aboriginal kinship makes our people particularly susceptible to the social epidemic of grog abuse – our social relationships can be easily exploited/distorted by the imperatives of addiction. We need to understand and recognise when and how this happens.

“Determinants” and “upstream issues”

¹² Edited and extended extract from the *Indigenous Roundtable* paper.

Many professionals in the health bureaucracy talk like parrots about “determinants” and “upstream issues” when they talk about poor health and when they talk about grog and drug abuse. They are confused and they cause confusion.

Diet and nutrition, exercise, housing and environmental health, smoking, grog abuse, unemployment, overcrowding – these might properly be called “upstream issues” and “determinants” of poor health. These are the upstream contributors to the problems that are soon manifested in the clinical health care system.

But environmental factors, social problems, material destitution et cetera are *not* “determinants” of grog and drug abuse, as I have heard senior health professional claim. This is a basic mistake made by the health professionals. They conflate the determinants of poor health with the factors involved with grog and drug abuse.

There are many Aboriginal people who are in good employment who have serious grog and drug abuse problems (eg. workers at Cape Flattery Silica Mines near Hope Vale develop severe drinking problems because of the ready availability of eight beers per night and the fact that social life at the mine revolves around alcohol). There are many people in over-crowded conditions who do not have grog problems and so on and so on. The point is that these factors might contribute to the *susceptibility* of people to grog and drug abuse, but they are not *determinants* of grog and drug abuse. This mistaken analysis by health professionals is in fact a version of the symptom theory: grog and drug abuse is seen as a symptom of poor housing, unemployment et cetera. But substance abuse is a dynamic epidemic and we must not conflate measures that might influence susceptibility in a socially more functional community with the measures that are now necessary to halt and cure the devastating epidemics, developing a conscious social ideology being the most urgent. As I stated earlier, the analysis is doubly mistaken: no or very little individual susceptibility is nowadays needed to get sucked into substance abuse, and treating the factors that originally might have made an established substance abuser susceptible will not influence his or her addiction, which is a condition in its own right and independent of personal history.

This mistaken understanding of the grog and drug abuse problem in our community by Queensland Health underpins their longstanding and trenchant refusal to accept any particular responsibility for helping us to deal with the problem. They think that housing, employment, economic development, education has to be fixed before we can fix the grog and drug problem, and they say (rightly) that other government agencies are responsible for helping to fix these other things. Yes, we will need to deal with these related issues (because they affect susceptibility/risk), but the factors underpinning our grog and drug problem are those mentioned in section 1.3 above.

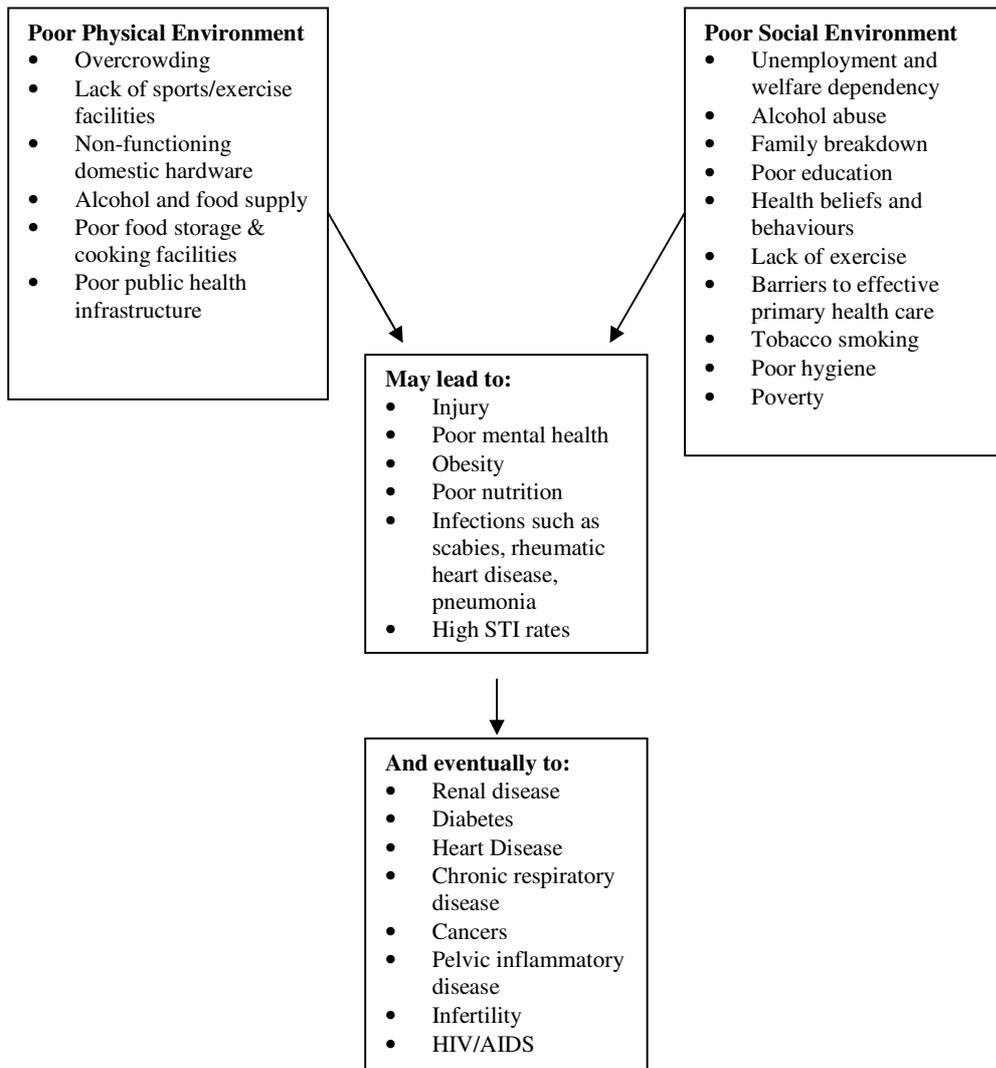
So we are not saying to Queensland Health that we have to solve the wider social and economic circumstances of our people in order for us to deal with the grog and drug problem. We want them to help us, where it is appropriate, in our strategies to tackle the

problem. Our strategies will have an element of medical health care – but this will be a small part of what needs to be done.

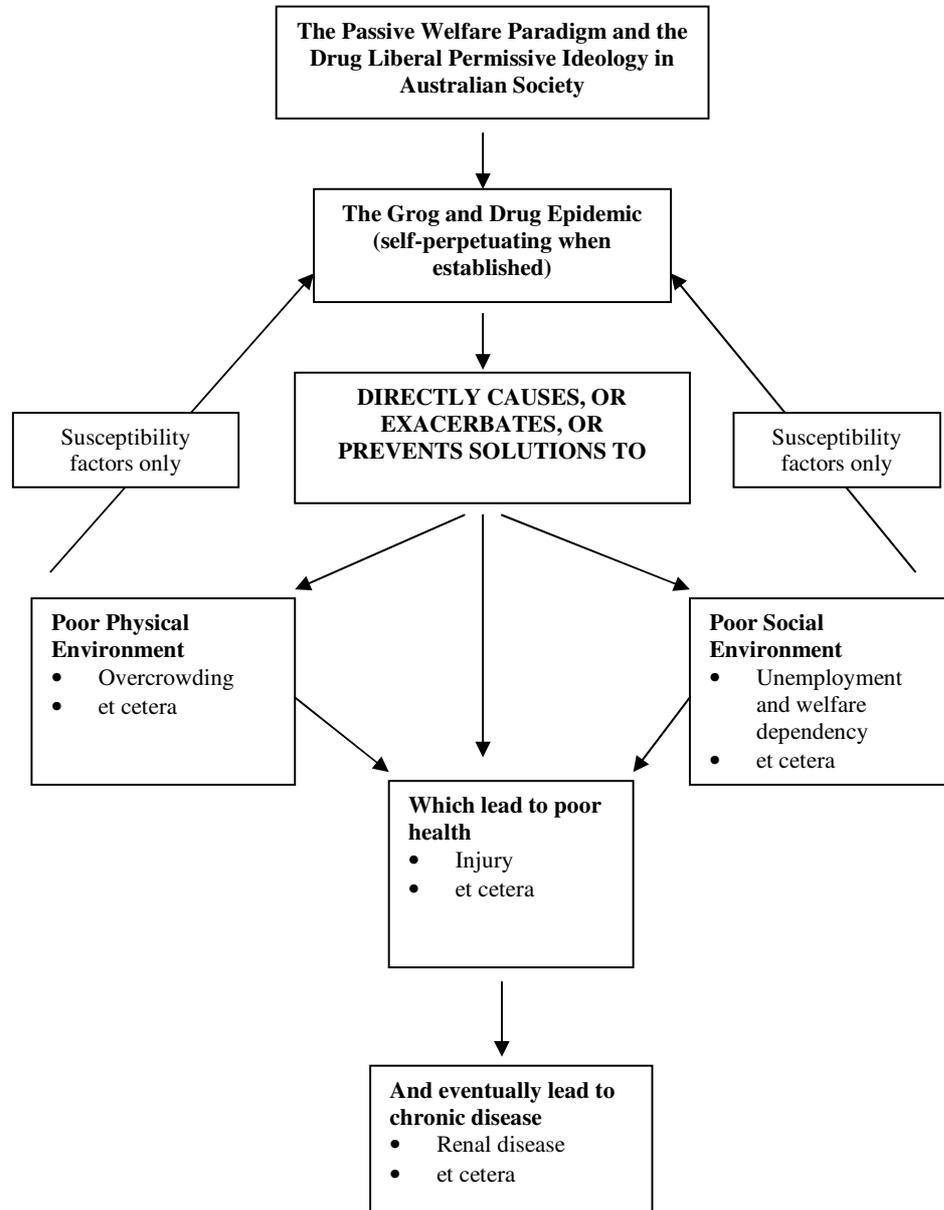
The real question that we have to confront with Queensland Health is: why are all of the available resources going into dealing with *the results* of our grog and drug problem (which is within their domain) – injuries, chronic diseases et cetera that are dealt with in the hospitals and clinics – and there are no resources going into *the (most obvious) cause* of these problems: the grog and drug epidemic within the community? The answer is that there is an entrenched health care *industry* that is sustained on the perpetuation and exacerbation of the health problems in our community.

In fact grog and drug abuse is frequently the determinant of poor housing and environmental health, overcrowding, smoking, stress, poor nutrition, spread of STDs, lack of exercise, even unemployment and of course injuries. It is a determinant of these “upstream” factors because it turns good housing into poor housing, disables people from taking up opportunities (for employment and recreation et cetera), and disables communities from gaining the peace of mind to deal with difficult changes in nutrition, exercise, health awareness et cetera. How can people who are struggling with the violence, social disorder, monopolisation of resources and stresses associated with grog and drug abuse – then think about dealing with smoking, exercise and diet? They can’t. We have to get on top of the grog and drug problem first.

This is the way Queensland Health understand the upstream determinants of our poor health which they say is based on an 'evidence-based' approach



This is a more 'evidence-based' understanding the upstream determinants of our poor health



Ultimately, the main determinants of our grog and drug problem are the passive welfare paradigm that has taken hold of our society and the drug liberal ideology in Australian society at large. The former creates (i) idle time and no sense of purpose and (ii) unconditional money supply. The latter provides (i) space for drug dealers to operate and unrestricted alcohol supply (availability) and (ii) an impotent response from society (defence for abuse, facilitating abusive life styles, hesitant law enforcement et cetera).

These true underlying issues then allow the epidemics to spread.

The grog and drug epidemics are then, *today*, the main causes of the alleged "determinants" of ill health (bad housing, social dysfunction et cetera). Of course much misery existed before the substance abuse epidemics, but it is obvious that material and human resources are just swallowed up by the epidemics. The grog and drug problem makes disadvantage more disadvantageous, it makes poor education worse, it makes good housing bad. And the combination of passive welfare and the grog and drug epidemics is fatal. The epidemics frustrate and prevent solutions to social and economic problems.

The unavoidable conclusion to be drawn from this is that working with the alleged determinants of poor health will be futile if we do not at the same time work with the passive welfare paradigm and the social ideology that underpins the grog and drug problem.

Of course this model for understanding our grog and drug problem is a simplification too, but it has been necessary to point out the large hole in the thinking of Queensland Health and the health industry generally: the lack of discussion about the self-perpetuating epidemics that are the main obstacles for progress today, and the causes and dynamics of these epidemics.

"Harm reduction", "clinical care", "public education programs", "dynamic poster workshops [!]", "family violence strategies", "school attendance strategies", "life promotion programs", "economic development strategies" – these are all either (i) diversions from what really needs to be tackled or (ii) they are totally futile or (iii) will have only marginal and temporary success as long as we don't confront the grog and drug epidemic amongst our people.

The word combination "Aboriginal health" to describe our problems as a people, is a terrible euphemism. We should call things what they are: passive welfare injuries and substance abuse epidemics. We are potentially the most privileged people in the world. We have our continuous connection to this large and beautiful land, the best natural foods, and many more things that other more successful people can never have.

2. ELEMENTS OF A STRATEGY

2.1 Our people need to first properly understand the problem – the individual addiction, and the *social* problem

It is not possible to prescribe a plan for the implementation of a grog and drug strategy in respect of a particular community, as it will necessitate a lot of improvisation and adjustment to the relevant local circumstances and opportunities. A community strategy will need local champions and facilitators, and it will need to take into account all of the opportunities available in the community to contribute to the strategy.

So we cannot write up a “plan” or a “strategy” that can just be implemented step by step. Working at the family and community group level will require careful consideration of the best opportunities in the particular circumstances.

But we can’t just continue to send people and resources out there into the communities to “do something” about the grog and drug (and violence) problems. If we are serious about a strategy, there are things that will need to be done at the regional and community levels to support the counselling and development work with family and community groups on the ground level – and to ensure that there is institutional support for community strategies.

The intention here is to just identify the main elements of a strategy, rather than setting out detailed strategies and ideas. There are many ideas and options for community strategies that arise from the foregoing analysis – and which can give effect to the elements identified here.

However there are two fundamental points that must underpin a community strategy:

1. The community strategy must be aimed at creating an environment which makes it more uncomfortable for substance abusers to continue with the abuse than to quit. There must be no more unconditional support if people don't change (ie. there must be a material cost). And, very importantly, there must be an immediate rejection of abusive behaviour by the environment (ie. there must be a social and emotional cost). The crucial point is to try to reverse the deeply rooted conditioning that I described earlier by making discomfort follow directly on doing the wrong thing. Presenting people with clear alternatives in this way (do the wrong thing and suffer immediately or do the right thing and be rewarded) has a superficial resemblance to the most common suggestion in the current debate: overcoming Aboriginal disadvantage by creating jobs and deliver the services we don't enjoy so that we will choose to leave abuse behind voluntarily when given a chance, and young people will be relieved of rural boredom and feel that they have a future and stirred by this to stop destroying their brains. I'm not quite sure myself what this waffle means, I'm just quoting from the current debate, because I don't have a clue how you go about creating

"a future" for somebody (I mean in practice, not just talking about it, parroting a stock phrase). But this favourite progressivist strategy is flawed because the addicts will choose both the abuse *and* the benefits of service delivery, which they will use as a lubricant to lessen the frictions arising from an abusive lifestyle.

2. The other main element of the strategy must be enforced treatment, because we need a cure for the current epidemic. The absolute intolerance of illicit drugs, absolute enforcement of social order, and enforced treatment is the core of the strategy. In order to cure an epidemic there must be involuntary, mandatory and humane treatment of people who are engaged in abuse. Everything that the addicts encounter must be designed to force them into that treatment. Every law, every social norm, every action by government and community organisations, every word the addicts hear must be consciously designed with this purpose in mind.

As I said earlier, concentrating on lowering susceptibility for turning to substance abuse (prevention) is less relevant in the immediate crisis, and can only be a supplement that might have some good effects on established addicts if it is part of an enforced treatment based on abstinence, but it can prevent further spread of substance abuse if the main strategy is in place.

Much of our thinking about grog and drug addiction is not our own. We have in fact learned the thinking from people involved in service delivery, from professionals and quasi-professionals, and from the confusions and prejudices of the mainstream culture. Our thinking is also influenced by the social impact and pressures of the addiction epidemic itself: sober people come to believe that the drinking of their addicted relatives is because of their problems, rather than their drinking being the cause of their problems (so we excuse the addiction because it is supposedly not the primary problem).

We take on wrong thinking, and the thoughts become a habit, and our whole approach is conditioned by what we have (unconsciously) taken on from the dominant thinking.

This is how the symptom theory came to be the dominant explanation of our grog and drug predicament. Whenever I thought about our addiction problem, I always used to say "yes, but grog is just a symptom of a great many underlying problems" et cetera. I have since asked myself: "Where did I get this symptom thinking from?" The answer is that I have heard many other people explain it in the same way and I have read things to this effect. I understand that I have just taken on this destructive and wrong thinking like a parrot.

We have to stop being parrots and start our own thinking.

2.2 The fallacy of trying to "normalise" drinking when confronted with an epidemic

Given the large number of problem drinkers in our social web and the existence of the epidemic – who really believes you can *incrementally* reduce the problem from (say on a scale of 1-10) an 8/10 problem down towards a “normal” 1/10 level? Alcoholics cannot “normalise” or “control” their drinking – they must rehabilitate and abstain.

This is the most difficult issue. Many people express the view that abstinence is not going to work as a solution – rather there must be controlled or moderate drinking.

Anybody who thinks for a moment about the problem would acknowledge that the only long-term solution for alcoholics is abstinence. There can be no “moderate” or “controlled” drinking for people who have rehabilitated from severe alcohol addiction.

And there are too many people in our society who are alcoholics – for whom abstinence is the only choice. How can this reality be dealt with if our strategy is to “normalize” drinking? We can’t normalize drinking amongst alcoholics.

The question is: what should happen with those people who are “moderate” and “controlled” drinkers and people whose drinking problem may be getting more and more out of control and may develop into alcoholism in time? We need to give further consideration, firstly, to the role of moderate drinkers in the perpetuation of the grog epidemic and, secondly, the role they could play in a strategy to overcome the problem.

Abstinence, prohibition and controlled supply

It may be that we need a strategy that is aimed at supporting alcoholics with abstinence, and this may not necessarily involve long-term prohibition for a community. We could think about a period of prohibition. The (as yet undeveloped) thought is that a strategy to engage alcoholics in abstinence and rehabilitation needs to include a stop to the current pattern of drinking and supply in the community. The (as yet undeveloped) thought is that when a community makes a democratic decision to adopt a strategy to combat grog and drug problems – then this needs to be marked by a dramatic commitment to change the current pattern of drinking and supply. A period of prohibition may serve the following purposes:

- as support for people with drinking problems from moderate drinkers and the rest of the community
- as a circuit breaker and symbolic departure from the process of recruitment of young people into the drinking vortex
- a clear message that the decision of the community to confront its problem is going to be enforced – and that a different standard is going to apply in the community from the *laissez faire* standards which have so far prevailed in the community and which prevail in the wider society

- as a clear message that when prohibition is lifted, the old pattern of drinking and supply will not be allowed to re-emerge. Alcohol will be reintroduced on completely new terms and conditions.

A managed system of alcohol supply could limit availability:

- in terms of location (say, limited to consumption at the outlet). The legislation establishing the Alcohol Law Council at Aurukun is one example of how supply and drinking places could be controlled spatially within a community, though by itself it was not effective
- in terms of times (say Fridays evenings and Saturday evenings only)
- in terms of occasions
- in terms of amounts
- in terms of kinds of alcohol

These are as yet undeveloped thoughts and much more discussion and consideration of the options and ideas needs to take place.

Moderate drinkers need to understand that, though their drinking might be controlled, they are part of a social web that is infected by an epidemic. So they cannot just pretend that they can continue their moderate drinking whilst surrounded by alcoholics. They have to take responsibility for the social problem and help their families to get out of the problem

Alcoholic drinkers and the moderate drinkers are part of the same social web. I constantly see moderate drinkers (and non-drinkers) participating in the early “happy” stages of a drinking session – “I’ll have a couple of beers with my cousins” – and then leaving the heavy drinkers to the misery and violence that comes later on in the aggressive, paranoid, depressive stages.

So if we are to confront the social nature of the grog problem in our communities, our strategies cannot be blind to the impact of moderate drinkers on the ability of alcoholics to deal with their problems. Also, as mentioned above, we need to consider the role that moderate drinkers play in the recruitment process: it may be that *debut* drinkers are following the example of moderate drinkers rather than the alcoholics – “I’ll handle my grog, I’m not gonna be like those goomies”.

2.3 AA method as a starting point for a *social* as well as individual strategy

We need to look at the AA method and see how it could be adjusted to an extended family/mates social network basis so that we develop *a social* strategy, not just an

individualised strategy. This could be a focus of family and social networks counselling and planning strategies.

But we must reconsider where we focus our recovery/rehabilitation effort. Traditionally, rehabilitation centres offering AA programs to individuals have aimed for isolation from the community – somewhere away from the main village, or out in the bush. But these past efforts, which have had success with some individuals, but have never made a dent in the overall social problem, and the programs at Hope Vale eventually closed down did not confront the epidemic entrenched in the social webs down in the village.

This meant that (i) people trying to get off grog through the AA program went straight back into the social pressures of the epidemic and fell off the wagon and (ii) nothing was done about the epidemic's recruitment of new addicts.

Whilst isolated recovery and reflection facilities might have a role to play in a strategy – we must be very careful not to pretend that we are dealing with the problem through these facilities. If we do not deal with the problem down in the village and in the whole community social web – then we are not dealing with the main problem.

The relevance and usefulness of AA

There appears to have been a rejection, in the Aboriginal health scene, of AA as a method for dealing with the grog problem, though some communities have had AA groups operating at various times with some success. Some of the objections I have heard are that AA was not 'culturally appropriate' and that it was 'too religious'. One of the arguments in favour of it seems to me to be that it need not be an expensive method.

Of course from the analysis set out in this paper, it follows that there are shortcomings to AA. Firstly, even if we had successful AA programs operating which rehabilitated alcoholics, we would only be affecting the *prevalence* of the problem – not the *incidence*. In other words we would not be tackling the recruitment problem. Secondly, and this flows from the first point, we have to confront grog as a *social* problem – not just an individual problem.

But we shouldn't just reject AA for the reasons that others have rejected it. We need to look into the methods of AA and see how we could possibly use it in our social strategies. The establishment of AA groups could form part of a community's comprehensive strategy for dealing with grog.

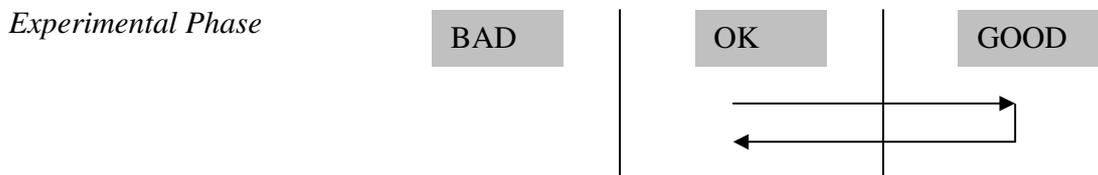
In particular we should look at the teaching methods and resources developed by AA. I found the following explanation from a video presentation by an AA Counsellor¹³ of the

¹³ Roger Sigston, "Chemical Dependency", "Unmanageability", "Culture and Alcohol", "Denial in Drinking and Sniffers", videos produced for the Council for Aboriginal Alcohol Program Services, Darwin, Northern Territory

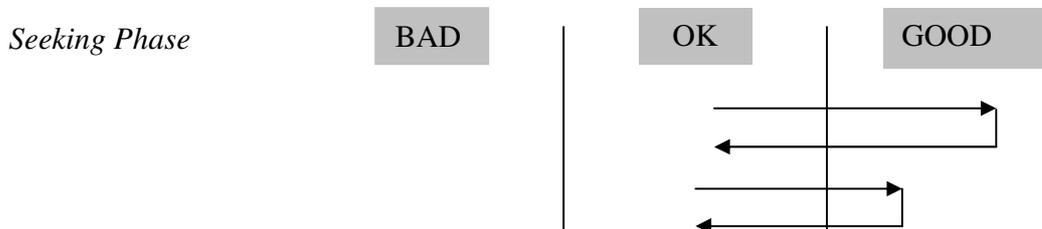
process of addiction and dependency, particularly insightful. The Counsellor illustrated what he called a “Feelings Chart”:



He explained that normally we hover around the “okay” mark, sometimes feeling good and sometimes feeling bad. These are the normal ups and downs, highs and lows of life. Then he explained the process of experimentation with a drug.

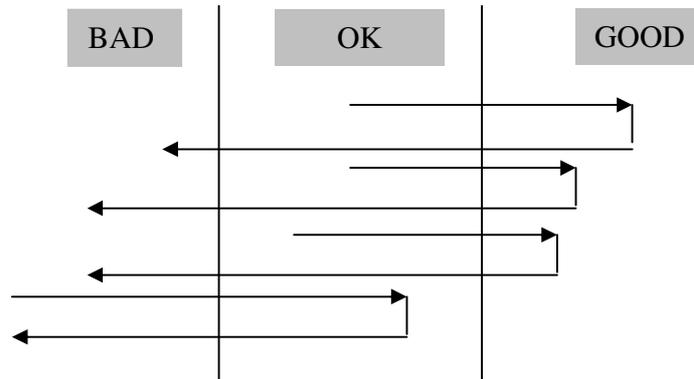


During the experimental phase we discover that the drug produces some pleasurable effect, so we go from feeling okay to good. We soon come to know the good feeling produced by the drug and we then seek the same effect during the “seeking phase”.



During the seeking phase we may discover that the effect of the drug was that it produced relief from stress or anxiety, or was pleasurable – and we are seeking the same effect. But it is during the seeking phase that addiction is likely to develop. As our seeking becomes habitual then we are moving towards the dependency phase. Our use of the drug then becomes increasingly problematic. In fact our use of the drug results in more bad feelings and problems, than good. The “happy” phase of our drinking circles does not last long – soon we’ll be arguing, soon there will be accusations, soon there’ll be insults, soon we’ll be fighting.

Dependency Phase



Eventually, we end up needing the drug just to feel okay. We no longer feel particularly good from taking the drug; it just temporarily relieves us from the bad state we are in when we don't have it.

As simple as it is, I found this explanation of the descent into addiction very informative and useful. And more compelling than other "awareness" and "health promotion" materials that I have seen. In relation to grog, the adverse physiological effects are well appreciated by Aboriginal people: we can see the effects plainly with injuries, kidney failure requiring dialysis, early deaths et cetera. What is more compelling are insights into the social and personal operation of addiction epidemics.

2.4 Development of a community grog and drug plan including an Aboriginal law and order strategy

Our grog and drug problem is a central problem of huge scale. Our efforts to tackle the problem cannot be marginal, half-hearted or piece-meal. Once we decide to confront the problem, we must aim for a comprehensive strategy at the community level. Many of the social and official mechanisms and facilities that are necessary for the implementation of a comprehensive strategy will take time and a focused effort to put into place. A community strategy should be based on a widespread understanding and discussion of the problems through families and community groups.

Once a community decides on a comprehensive strategy for dealing with grog and drugs, then they must have the ability to implement and enforce their strategy. This means that rules need to be given enforceable status and there must be an effective enforcement of them. We must develop under State legislation mechanisms to buttress, support and require local justice mechanisms to restore law and order in communities and to enforce rules in relation to grog and drugs. The development of a community grog and drug plan will require partnerships between the community, regional Cape York organisations and the State, and it will require a concerted effort to put all of the necessary elements into place.

2.5 Completely eradicate illicit drugs

There can be no other policy other than a complete intolerance of illicit drugs and there must be a law enforcement capacity to put this policy into effect. This is only a matter of determination and unity. We can make it impossible for the consumers to continue if we have the emotional courage to confront our own family members. And the suppliers are nothing to be afraid of. No matter how much money and violence criminals and organised crime can mobilise, the democratic state can always mobilise more money and violence. A furious democracy is a formidable war machine, said General Dwight D Eisenhower about his campaign against Adolf Hitler's forces.

And it goes without saying that, if we are serious about attacking these problems, it is unthinkable to have anything to do with white people who use illicit drugs or tolerate such behaviour in their families or associate with such people. Such people must be removed from our organisations and communities must make it clear that white people involved with drugs will have to remove themselves from our land, otherwise we will have to assist them with that.

CONCLUSION

At this stage of the grog and drug epidemics in Cape York the greatest susceptibility factor for our Aboriginal people to be recruited to addiction is the mindset that lurks in our culture, our ideology, our psychology: to be ridden with problems like violence, grog and drugs *is to be Aboriginal*. That these states of dysfunction that we endure as a people are treated as if they are ‘natural’, ‘normal’, ‘to be expected’, ‘inevitable’, ‘hardly surprising’, ‘can be understood’, ‘justifiable’, indeed perhaps even ‘innate’ to our identity as a people and to our place in the wider world – means that our culture and identity is bound up with dysfunction.

This is where the social ideology of our Aboriginal society in Cape York has ended up: in a culture of self-defeat and self-destruction that feeds the epidemics of grog and drug abuse. Grog and drugs have been set up as the palliative of our low self-image and self-esteem, grog and drug taking and associated behaviours have been set up as the last expression of identity, the last act of wilful defiance against a world in which we have come to see ourselves (and others ruthlessly encourage us to see ourselves) as hopeless victims (who can do nothing else but fall victim to addiction). Therefore, when asked to explain our chronic drinking we end up saying either in a resigned self-deprecation, or in tragic humour, or in hollow defiance: "We Aboriginal people, we alcoholic people".

However, the fact that our people are *highly susceptible* to these epidemics should not make us lose sight of the incorrectness of the symptom theory. We must separate our susceptibility factors from the causal factors and remember that substance abuse epidemics also frequently occur in wealthy and functional societies – and they are also frequently absent in poor and traumatised societies.

And this will be a difficult point for those who know only too well the widespread occurrence and terrible trauma in Aboriginal families. I do not deny trauma as a major issue in our communities. Of course much of the trauma we must contend with today is the directly consequence of the growth of the drug and grog epidemics – and the physical and sexual violence that have followed in their wake. This trauma is often indistinguishable from the effects of inter-generational dysfunction in families and communities. I refer readers to my comments on the subject of trauma in *Our Right to Take Responsibility*.

Counselling is a key need. But trauma is a notoriously difficult issue to treat and I am sceptical about the growing number of ‘social and emotional health’ programs – a new health industry is spawning – because of their tendency to promote ‘symptom theory’ thinking. To the extent that such counselling and family development programs promote symptom theory thinking, they will be destructive and counter-productive. We must be careful to ensure that our counselling facilities and approaches are based upon a sound understanding of substance abuse epidemics.

The point is this: we are highly susceptible to grog and drug abuse, because of our personal and family history and background, but substance abuse epidemics have their own dynamics and we must understand that addiction is a condition in its own right, not a symptom.