

2004 AMA ORATION

In honour of the late Professor Ross Webster

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Australian Medical Association National Conference

28 May 2004

Introduction

Let me first thank the Australian Medical Association for inviting me to deliver the 2004 AMA Oration. To the family of the late Professor Ross Webster: it is my honour to deliver this year's oration in honour of his memory.

This evening I will extend my discussion of substance abuse first outlined in my inaugural Dr Charles Perkins Memorial Oration in 2001. In that lecture I set out an analysis of substance abuse in Aboriginal Communities based on the late Swedish Professor Nils Bejerot's compelling analysis of substance abuse as psycho-socially contagious epidemics: that is substance abuse problems are a social equivalent to biological epidemics involving growth through recruitment of novices by established users.

Healthcare Services to Cape York Peninsula

Before proceeding further, allow me to seek the support of the AMA for our health plans for our people in Cape York Peninsula. The health care services to our people are exclusively provided by the Queensland Government through its networks of clinics in indigenous communities and small hospitals in the towns. There are no indigenous medical services or GP services.

There is a longstanding and unfulfilled need for doctors in Cape York Peninsula and myself and my colleagues in the leadership of our community, are developing a proposal to submit to the Federal Government for the Commonwealth to

provide funding through the cashing out of Medicare and the Pharmaceutical Benefits Scheme to communities that simply do not have access to GP services - to employ doctors through a community-controlled health service organisation for the region. The exclusion of our people from this federal funding must end, and we must have the means to control the provisioning of the services which are desperately needed: those of doctors and indigenous health workers. Providing funding under the Primary Health Care Access Program or similar programs through Queensland Health would not answer the need for community control. Federal funds should be provided through community controlled health service organisations.

There is good reason why the AMA should consider providing its strongest support to our submissions for Federal support. When we talk about "community control" we mean community responsibility, where our people do not just concern ourselves with the provisioning of the primary health care services, but we take responsibility for the upstream public health issues which underpin the poor health of our people: substance abuse, tobacco smoking, poor environmental health and poor nutrition. In Cape York Peninsula our whole agenda is based on the notion of responsibility: we have to take charge of our problems. If we can add the best health care services provided by doctors and health care workers with the kind of concerted and comprehensive public health strategies which we in Cape York Peninsula have developed (and are still developing) - then we will see real improvement in the health of our people.

Our confrontation with substance abuse is testament to how serious we take our primary responsibility to attack the causes of the chronic diseases which so disproportionately and so disastrously afflict our people. I hope that the AMA will join with us in a pincer strategy to fix up Aboriginal health.

In order to combat our most difficult underlying health problem - substance abuse - we need to first understand the nature of the problem, so that we can formulate effective strategies to combat it. The reason why I take substance abuse as our primary challenge is because substance abuse is either:

- the direct cause of ill-health and other social and economic problems, or if it is not, then it
- exacerbates any pre-existing problems, and in any case
- prevents and frustrates any solutions to these problems.

This last reason for focusing on substance abuse is the catch-all reason: even people who do not engage in substance abuse are affected by it, and any attempts to solve their health problems is prevented and frustrated by the chaos, stress and misery occasioned by substance abuse and the social breakdown it brings with it. This is why we choose to first confront substance abuse as a problem in its own right, rather than as symptom of other personal or social problems. This latter misconception of substance abuse Nils Bejerot called the "symptom theory".

Factors Required for the Outbreak of a Substance Abuse Epidemic

Trauma and dispossession are today not the most significant determinants of an individual's descent into substance abuse. Five factors are needed for substance abuse to take hold in a community:

- the addictive substance being available
- money to acquire the substance
- spare time to use the substance
- the example of others in the immediate environment, and
- a permissive social ideology in some circles of the community.

A widespread permissive social ideology will greatly facilitate an outbreak, but an outbreak of an epidemic of abuse can break the spirit of those who resist. Two factors that will allow epidemics to grow are therefore:

- a failure to defend higher social standards in the community as a whole, and
- permissive or hesitant government policies.

Dynamics of an Epidemic

The people who first become substance abusers are those who are most susceptible. As the number of addicts grows, it becomes less a breach of social norms to begin abusing substances. The symptom theory can be correct in a limited sense: the first voluntary consumption of potentially addictive substances can be a symptom of problems and bad circumstances. But as the epidemic grows, such circumstances become increasingly irrelevant as an explanation for an individual's first experimentation with addictive substances.

Our blindness to this fact, when we have witnessed in Cape York Peninsula how strong people who have struggled to take responsibility for our families and communities, and young people who have not been traumatised (and in fact have been brought up by responsible parents) get sucked into foolish and destructive behaviours, is testament to how severe our confusion has been.

Voluntary Rehabilitation and Voluntary Prevention Is Not Enough to Curb Epidemics

Even under optimal circumstances, life is difficult and full of conflict. We cannot improve the quality of life to a level where an addict voluntarily leaves her or his antisocial lifestyle and joins us in our struggle for a better future. The addict's most likely response will be to use all the material and human resources we offer to facilitate an abusive lifestyle.

Nils Bejerot pointed out that public opinion is so dominated by symptom theory thinking that we fail to see that substance abuse epidemics can to some extent be compared to epidemic diseases. When faced with a contagious disease we make a clear distinction between prevalence (the number of affected people at any one time) and incidence (the number of new cases over a period of time). We realise

that we must reduce the incidence and we concentrate our efforts on dealing with those who might spread the disease. However, when confronted with psycho-socially contagious substance abuse epidemics, society is reluctant to deal decisively with those most likely to introduce other people to the use of the addictive substance, namely those who are at a relatively early stage of substance abuse. It seems likely that the younger, less dysfunctional substance abusers, who do not see their use as a problem and do not seek rehabilitation, introduce many more people to the addictive substances than the advanced addicts who are so weakened that they might consider rehabilitation.

The epidemics cannot be cured with policies that are based on voluntary rehabilitation and clinical care. When the social, medical and economic problems become too annoying, after many years of abuse, an addict might consider voluntary rehabilitation. 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 may stop drinking. But by this time he or she has already done most of the damage he or she could have done: directly by introducing other people to abuse and addiction, and indirectly by causing chaos which makes the community more susceptible to the spread of abuse.

Helping people to lead a better life in their last years or decades is a *humanitarian* question, but it probably has little impact on the development of the epidemics of substance abuse. The focus must be on effective strategies to influence the behaviour of the addicts who are spreading the abusive behaviour and recruiting new (young) people to substance abuse, and on strategies to influence the behaviour of potential new recruits.

To say that there is no widespread understanding of the importance of incidence would be an exaggeration. The problem is that the emphasis on rehabilitation for indigenous people is too strong, considering that voluntary rehabilitation cannot reasonably have a great impact on the epidemics. Currently, discourse on prevention is not only secondary to the discourse on rehabilitation, it also avoids the evident truth that prevention must be based on controlling the factors money and spare time - in other words, making monetary assistance conditional as a means of influencing young people's behaviour, and limiting their freedom to do as they please.

Aboriginal Experiences Show That Our Current Thinking Is Wrong

In conclusion, the experiences of many Aboriginal communities seem to support Nils Bejerot's thesis: lack of management of and attention paid to the factors money (in the form of passive welfare); idle time; access to addictive substances; the influence of early norm-breakers; social norms, and inadequate government policies can cause the outbreak of epidemics of substance abuse and then exacerbate them. Three observations disprove the common notion that the current state in Aboriginal communities is a symptom of dispossession. First, the prevalence of abuse of alcohol or cannabis or other drugs has in many communities reached such levels that dispossession and personal problems are not plausible explanations for people's behaviour. The proportion of emotionally disturbed people before the epidemics broke out was not large enough to explain the large number of people who became substance abusers during the passive welfare era. Second, communities which have been less severely affected by dispossession are typically at least as badly affected by the substance abuse epidemics as the more dislocated and disrupted communities. Third, the social deterioration was concurrent with material and political improvements, which suggests that the epidemics were either not affected by the policies for reducing Aboriginal disadvantage, or were accelerated by some elements of indigenous policy.

The Concepts "Evidence-Based Policy", "Substance Abuse is a Health Issue" and "Harm Reduction"

Our strategy in Cape York Peninsula will be criticised. Advocates of harm reduction will count us among those who oppose substance abuse solely on moral and ideological grounds without examining the questions. Our opponents will assert that their approach is "evidence-based" and that substance abuse is a "health issue".

To overcome initial resistance in public opinion, we need to analyse the claim that substance abuse is a "health issue", and explain what we mean when we say that substance abuse is a political question.

Some health problems such as polio, Parkinson's disease and arthritis, are more strongly determined by biological factors than social and political factors, though many diseases are exacerbated by societal factors. Only great advances in medical science help us reduce such problems significantly.

Other health problems are closely connected with the development of the economic organisation of our civilisation. The constant transformation of our society and our economy continues to have both negative and positive effects on mental and physical health. However, it is difficult to do anything about the fundamental features of our economy at any given time.

Poverty and lack of development is a determinant of health problems that is less relevant to mainstream Australia. Addressing such health issues is often more a political question than a medical one and rapid advances can therefore in theory be made. However, reducing poverty globally has turned out to be an arduous long-term undertaking.

Substance abuse issues are different to the three groups of health issues I just mentioned above because substance abuse issues are closely connected with social ideology and social standards. There is a strong biological component in an individual's addiction to a highly addictive substance once the addiction is established. But the exposure to psychoactive substances and the behaviour of beginning to administer psychoactive substances is socially determined. Comparatively rapid changes in attitudes influence the intensity of problems with substance abuse and addictions to processes like gambling. How we deal with these problems is predominantly a social and political question. Public opinion alone can in this area achieve quite a lot; it need not wait for the economic and scientific progress that is necessary to deal with our biological limitations and health problems caused by underdevelopment and by the fundamental features of our economy at its current stage of development. The demise of smoking illustrates the principle: it has rapidly shifted from being a normal behaviour to a behaviour unwanted by a majority of people.

It is more than unfortunate that the phrase "health issue" is so prominent in public discussion about addiction and substance abuse. The classification "health problem"

obscures the importance of political and social ideology, and of the choice of individuals for the development of such phenomena.

If one conceded that substance abuse should be seen as a health issue, harm minimisation and harm reduction might be logical responses. If something cannot be avoided, its harm must be minimised.

The ideology of "harm minimisation" (which includes "supply reduction", "demand reduction" and "harm reduction") is unfortunately the official strategy of the Australian governments. Demand reduction and supply reduction (such as stopping heroin at or outside Australia's borders) are uncontroversial, but "harm reduction" is founded on the following assumptions:

- that we have to accept that we will never eradicate the problem of abuse of legally available and illicit substances
- that, having accepted the entrenchment and inevitability of substance abuse in society, it is more realistic to deal with the consequences and circumstances of substance abuse.

The most persuasive argument in favour of harm reduction is that many of the negative consequences of illicit drug use for society and for the users are at least partly due to the fact that the substances are illicit. Our opponents also argue that there is no logical justification for the different responses to legal and illicit drugs. The consequences of the abuse of alcohol are very severe, but use of alcohol is not prohibited. We have an arbitrary situation today where it is legal to sell alcohol to dysfunctional addicts, but illegal to sell most other drugs.

Harm reduction policies erode the restrictive social consensus required to curb the psycho-social epidemics, but occasionally we need to prioritise between the struggle against biological epidemics such as HIV infection and the psycho-social epidemic of using psychoactive substances. A basically restrictive substance abuse policy cannot avoid making calculations about whether urgent health imperatives must occasionally take precedence over the negative consequences of condoning substance abuse. Adopting some

harm reduction policies is not an acknowledgement that the harm reduction lobby is generally correct; specifically, this does not amount to any concession to the libertarian undercurrent of harm reduction.

Does one camp have science on its side?

The phrase "evidence-based" is another catch-cry of anti-restrictive opinion in Australia. Politicians are naturally in search of solutions "that work", but they need to be aware that "evidence-based" approaches are not as neutral and objective as the phrase implies.

"Evidence-based harm reduction" implies a view of society and a political philosophy; it is not just an objective conclusion about what is inevitable. It sees the increasing number of widespread psychoactive substances as inextricably linked to the development of the most fundamental features of human culture. Its proponents reject our view that political and social collective action can remove a psychoactive substance from society, on the basis that our culture has reached an age of individualism.

If one holds that fundamental conviction, the "lab-rat" perspective of society, which is inherent in the notion "evidence-based", is realistic: one can change the circumstances of the lab rats by gathering evidence about what circumstances minimise the harm which the rats might do to themselves and to each other, but it would be futile to try to agree with the lab rats about how harm is going to be avoided altogether, or expect the lab rats to reach such an agreement amongst themselves, because rats are individualists incapable of reaching a social consensus about consciously upheld norms.

Attempts by lay people to challenge the substance abuse experts' definition of rational, evidence-based discourse will be met with condescension. Many people and political leaders all over the world have been opposed to so called "heroin trials". A WHO report on the neuroscience of addiction¹, summarised the debate in the following partisan terms: "The international debate on heroin-assisted treatment of opioid dependence, initially mainly political

¹*Neuroscience of psychoactive substance use and dependence*. World Health Organisation, Geneva 2004.

and controversial, tends to become more scientific and evidence-oriented". It is remarkable that one side in a debate about fundamental values should be dismissed as "controversial" and the other described as "scientific and evidence-based". The substance abuse debate is unique among political debates in that one side has managed to monopolise the name of science. However, the harm reduction lobby will never acknowledge that it represents one side (sometimes with extreme tendencies) in a political debate, rather than being the representative of science and objectivity in the struggle against ignorance.

Can people unite?

The advocates of harm reduction believe that "there is no approach to the use of drugs of dependence and psychotropic substances which will ever provide a drug free community"²; they do not believe that we can prevent the many illicit drugs from becoming endemic to our society.

This is where there is a sharp contrast between us and the harm reduction advocates in terms of our view of society and our social ideology. Harm reduction is based on the political judgement that it is impossible for a sufficiently large proportion of the people to reach consensus about norms and agree over strict and long-term rules about what is good for society. Attempts in that direction will, our opponents think, lead to both oppression and an increase in drug-related problems. In the absence of debate over the fundamental social theory underpinning harm reduction, those arguments of the harm reduction lobby will be persuasive.

We are of the opinion that people can unite if they explore the argument in a thorough democratic debate. The dividing line in this debate is firstly a difference in opinion about people's ability to unite and agree for the common good.

² Quoted from the Aims and Objectives of the Australian Drug Law Reform Foundation.

Opponents of Harm Reduction in the Right and the Left Must Unite

Rejecting harm reduction is not necessarily a conservative policy. In a Leftist analysis, the societal function of addiction is to compound disunity and political paralysis among large sectors of the population and make people less able to organise themselves, politically and socially. And Aboriginal people, at 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 curb by means of restrictions, the damage done by endemic problems of Australian society, such as alcohol and gambling.

Substance abuse epidemics can be dealt with if a broad coalition of democrats - conservatives, responsible economic liberals, principled social democrats and socialists and whoever is in favour of social order - unites against the progressivist Left and the "socially progressive" Right around a consistent, restrictive policy.

Forget about walking bridges; what ordinary non-indigenous Australians can and must do for Aboriginal reconciliation is to improve social standards in the country by rejecting illicit drugs in their own environment, and irresponsible use of alcohol and gambling.

Not Curbing Substance Abuse is Cultural Genocide

Those who disagree with our arguments should try to see things from a remote Aboriginal perspective. In Cape York Peninsula, alcohol, illicit drugs and gambling are not means of recreation but miserable sources of disunity, passivity, crime, violence, pain and death. Entire communities are affected, with the result that they can make no progress in any social or economic area. The mixing of alcohol and cannabis or petrol and cannabis causes violence, injury and death, and social and economic collapse.

The urban discussion of harm minimisation is irrelevant to our situation; the harm caused by pervasive addictions cannot be managed. We do not believe it is possible to implement widely different policies underpinned by contradictory ideologies in different parts of the country.

If, for example, the Australian mainstream decides to "liberalise" the norms regarding use of cannabis, the situation for Aboriginal people who fight for social order in the communities would go from difficult to hopeless.

Academics, Professionals and Most Politicians Have No Leadership to Offer

In this discussion I have tried to cover both legally available substances (alcohol) and illicit drugs.

My purpose is not to analyse in detail the many addiction problems of indigenous people, but to inspire questioning of the broad and diverse movement in Australian political, academic and bureaucratic thinking that goes in the direction of harm reduction, liberalisation, and perhaps controlled supply. Particularly among political leaders such an attitude is usually a very general idea which has far-reaching implications for their political behaviour; policy suggestions may be more or less radical in the direction of liberalisation, but they are variations on a theme. We believe that some basic convictions about substance abuse will determine how leaders and members of the public think about seemingly very different problems such as alcohol abuse in Cape York Peninsula and heroin use in Sydney. It is therefore necessary to respond to this basic philosophical tenet in broad terms, in order to show that there are well founded objections to the current trajectory and that a credible alternative route is available.

In 2001 Dr Alex Wodak invited me to speak at the yearly conference of the Australian Professional Society on Alcohol and Drugs (APSAD). Dr Wodak wrote that "if alcohol and drug prevention and treatment services for indigenous Australians is ever to be improved and receive additional funding, it would largely be the members of this organisation who will carry out this work or train those who do so".

This is precisely what must not happen in Cape York Peninsula. APSAD members, academics and experts generally make no contribution to the solution of our problems. Some of their writings are acceptable and occasionally insightful, but they have failed to exercise intellectual leadership

We have to do it ourselves. Not only the implementation, based on theory developed by others; we have to do the thinking.

What is Social Policy?

Finally I want to ask: "What is social policy?" People usually think about redistribution of wealth and government service delivery as the main components of social policy. The effects of passive welfare and service delivery have not been good in our region. Those effects have been compounded by failure of the governments (and indigenous leaders) to realise that a third pillar of social policy must be managing the factors that lead to increase of addiction and substance abuse.

The Greatest Policy Failure of Australian History

With the benefit of hindsight, the Australian people set up a lethal trap when indigenous people were exposed to the combination of passive welfare payments, idleness, and access to legal and illicit addictive substances and gambling. One marvels at the ignorance and lack of foresight that allowed Australian governments and indigenous and non-indigenous Australians to settle on such a policy after the end of the era of protection and official discrimination. How could we not see that the consequence would be short lives, illiteracy, tens of thousands of cases of severe sexual abuse and violent crimes, and cultural dissolution?

And that was not the end of the disaster. When the problems became undeniable, we together, indigenous and non-indigenous Australians, collectively started behaving like an addict and claimed that it was all a symptom of dispossession.

We laid the responsibility on earlier generations and convenient enemies like "racists", and, by adopting an analysis that identified a root cause that was wrong, we destroyed all prospects of people uniting to stop the disintegration. Also, the alleged root cause of racism and disadvantage was so intractable that we perhaps had no real hope in our hearts.

We need new hope. Indeed, Aboriginal people in Cape York Peninsula and the Queensland Government have shown during the last years that by paying attention to social expectations, governance, supply of addictive substances, money (welfare) and use of time, we can achieve what the flawed policies of the last century denied us.