



Australian  
National  
University

---

THESES SIS/LIBRARY  
R.G. MENZIES LIBRARY BUILDING NO:2  
THE AUSTRALIAN NATIONAL UNIVERSITY  
CANBERRA ACT 0200 AUSTRALIA

TELEPHONE: +61 2 6125 4631  
FACSIMILE: +61 2 6125 4063  
EMAIL: [library.theses@anu.edu.au](mailto:library.theses@anu.edu.au)

## **USE OF THESES**

This copy is supplied for purposes  
of private study and research only.  
Passages from the thesis may not be  
copied or closely paraphrased without the  
written consent of the author.

**DIFFERENCE AND INDIFFERENCE:  
AUSTRALIAN POLICY AND PRACTICE IN INDIGENOUS  
SUBSTANCE ABUSE**

**by**

**Margaret Ann Brady**

**December 1999**

**A thesis submitted for the degree of  
Doctor of Philosophy of the Australian National University**

## **DECLARATION**

**Except where indicated otherwise, this thesis is  
my own work**

A handwritten signature in black ink, appearing to read "Margaret Brady". The signature is fluid and cursive, with "Margaret" on top and "Brady" below it.

**Margaret Ann Brady**

## **ACKNOWLEDGEMENTS**

Many people have helped me with this research. A National Drug Strategy Fellowship at the National Drug and Alcohol Research Centre, University of New South Wales in 1995 enabled me to pursue my embryonic interest in the relevance of brief interventions for indigenous alcohol problems. Professor Wayne Hall of NDARC was instrumental in making this fellowship possible, and others associated with NDARC contributed much to my thinking, including Professor Robyn Richmond, Dr Alex Wodak, and Dr Sharon Dawe. Dr Ann Roche and Dr John Saunders were also helpful. Similarly, a short visiting research fellowship at the Centre for Aboriginal Economic Policy Research (ANU) in 1994 enabled me to research health policy issues at an important time in the debate over the administration of Aboriginal health. I am grateful to Professor Jon Altman for arranging this fellowship and to Dr Ian Anderson with whom I worked there.

An NHMRC grant in 1997-8 enabled a group of researchers including myself to work in partnership with an Aboriginal health service (Nunkuwarrin Yunti) in Adelaide, to undertake a study of the implementation of brief interventions in primary health care. This work forms the basis of one of the chapters in the thesis. I thank these collaborators: Dr Ross Bailie, Professor Wayne Hall, Dr Beverly Sibthorpe, and Ms Polly Sumner. I would also like to thank Ms Sandy Ball, Mr Basil Sumner, the medical staff of the service and the Aboriginal Health Workers for their willingness to participate in the study itself and in the qualitative interviews which followed.

Friends and colleagues in Canada and the United States were generous with their hospitality, introductions and insights during several research visits to North America. I particularly thank Andrew and Karen Chapeskie, Andrea Klymasz, Steve and Izzie Kunitz, Professor Mac Marshall, Dr Ginny McGowan, Dr John O'Neill, Dr Robin Room, Brad Schwarz, Jill and Alan Torrie, and indigenous and other staff at the Lake of the Woods District Hospital, Ontario.

The Australian Institute of Aboriginal and Torres Strait Islander Studies has been the base from which I have undertaken much of this research, and I extend my thanks to many colleagues at the Institute, particularly those in the research section and the library. I have been enrolled in the National Centre for Epidemiology and Population Health at the Australian National University, which has provided a helpful collegiate environment in which to work. I wish to thank my supervisors Dr Beverly Sibthorpe (Chair), Dr Len Smith (both of the National Centre for Epidemiology and Population Health, ANU), and Professor Wayne Hall (National Drug and Alcohol Research Centre, University of New South Wales) for their support, their prompt reading of drafts and wide-ranging and helpful commentary throughout. Professor Stephen Kunitz of the University of Rochester Medical Centre, New York, was also an indefatigable reader of drafts. Professor Kunitz has generously shared his long-standing experiences in indigenous health and substance abuse with me over many years and provided consistent support and friendship throughout the work. I am grateful to Dr Jeannie Devitt, Dr Les Drew, Jacquie Lambert, Jeremy Long and Dr Paul Torzillo who also read drafts of different chapters and gave of their long experience in Aboriginal affairs. Dr F.S. Soong kindly provided some historical background. Others who have supported and stimulated me one way or another in this endeavour are Professor Ross Kalucy, Graham Henderson, David McDonald, Dr Janice Reid, Dr Tim Rowse, Dr David Scrimgeour, and Bill Wilson.

I am also grateful for the academic and personal help of many friends including Bill Arthur, Britta Duelke, Mary Edmunds, Nic and Ros Peterson, Jerry Schwab, Di Smith, Aat Vervoorn and Carol Watson. Lastly I would like to thank Alan Thorne for his warm support and commitment to my work.

## ABSTRACT

This research addresses the ways in which alcohol problems among indigenous Australians have been conceptualised and acted upon by the people themselves, and by government policy-makers. The thesis considers two main questions. First, how has it eventuated that Aborigines have become excluded from national and international innovation in the management of drug and alcohol problems? Second, are mainstream models of best practice for alcohol intervention, particularly secondary prevention activities, acceptable to and feasible for Aboriginal people?

I examine how the growth of the indigenous rights movement came to underpin assertions of cultural difference from other Australians, which in turn influenced the growth of separate community-controlled health and other organisations. National policy-makers found it difficult to deal with demands for the recognition of cultural difference through the provision of special funds and separate services. As a result of this increased sensitivity, national policies often gave inadequate consideration to indigenous issues. Alcohol problems in particular received little expert attention, and the division of community-controlled alcohol programs from health services for Aborigines exacerbated these shortcomings. Aboriginal approaches to alcohol were influenced by a small group of charismatic activists who pursued a unitary position and remained insulated from the changes in policy and practice available to the wider population. While the health services came to be influenced by an all encompassing 'Aboriginal' definition of health - associated with the broad WHO definition of health emanating from the Alma-Ata Declaration of 1978 - alcohol programs maintained a narrow, disease-based focus.

Cultural difference is presented throughout the thesis as being a crucial issue, and it is analysed as a political construct with continuing salience in the face of the unequal distribution of resources. The constructions of difference are discussed and contested in the areas of culture and healing, in health, and in approaches to alcohol problems. I demonstrate that the politics of difference has masked the fact that many Aboriginal dependent drinkers manage to give up drinking, either on their own or with the

encouragement of a health professional, just as do others in the population. The politics of difference is also implicated in the rejection of innovative and varied approaches to alcohol problems emanating from mainstream treatment research. This has deprived Aboriginal people experiencing serious alcohol problems of access to a range of interventions which could assist them much earlier in their drinking careers. Some relevant approaches include brief and opportunistic interventions delivered by health professionals, which are found to be relevant and feasible for use with Aboriginal clients of primary health care services.

## **CONTENTS**

### **Introduction 1**

<b>Chapter One: From Civil Rights to Indigenous Identity</b>	<b>7</b>
1. Self determination	7
2. Aboriginal civil rights	9
2.1. FCAATSI	12
2.2. The Freedom Ride	13
3. Black Power or Aboriginality?	15
4. Utilising the court of world opinion	19
5. Aboriginal health in the international arena	23
6. Faith in the Commonwealth?	25
Conclusion	30
<b>Chapter Two: WHO and Constructions of Difference in Health</b>	<b>31</b>
1. The need for Aboriginal health services	31
2. The development of Aboriginal health services	33
2.1. Community participation and control	34
3. The Alma-Ata Declaration	38
4. The WHO definition of health	40
4.1. Critiques of the WHO definition	41
4.2. The elaboration of the WHO definition	43
4.3. The construction of polarised positions	45
5. The ongoing influence of WHO principles	47
5.1. The Northern Territory Aboriginal Health Worker program	50
6. The construction of an Aboriginal definition of health: 1981	54
6.1. A government-sponsored invention	55
6.2. Explicit and implicit motivations	58
Conclusion	59

<b>Chapter Three: Difference and Indifference in National Policies</b>	<b>60</b>
1. Making national policies	60
2. National health goals and policies in Australia	62
3. Whatever happened to the National Aboriginal Health Policy?: a case study	63
3.1. The National Aboriginal Health Strategy report	67
4. National HIV/AIDS research and programs: a case study	69
4.1. HIV/AIDs knowledge, attitudes and behaviours	70
4.1. Cultural appropriateness vs best practice	73
5. National Drug and Alcohol policies: a case study	77
5.1. The National Drug Strategy	79
5.2. National Aboriginal Health strategy coverage of alcohol	82
6. Difficulties in national policy development and Aboriginal input	83
Conclusion	90
 <b>Chapter Four: Constructions of Aboriginal Alcohol Use</b>	 <b>93</b>
1. Historical antecedents influencing Aboriginal perspectives on alcohol use	93
2. The problematisation of Aboriginal alcohol use	97
2.1. The wet position	98
2.2. The dry position	101
2.3. The separatist position	105
2.4. The outcome of the enquiry	110
3. Changes in international positioning on alcohol	113
4. Changes within Australia	116
5. Barriers to the dissemination of innovation	118
5.1. The separation between health services and alcohol services	121
5.2. Competing agendas	123
5.3. The legacy of the 1970s	126
6. The shift to theories of cultural loss	127

6.1. The Canadian Indian influence	129
6.2. The policy implications of these developments	133
6.3. An influence beyond their numbers	125
Conclusion	141
<b>Chapter Five: Contesting Difference</b>	<b>143</b>
1. Contesting the uses of cultural difference	144
1.1. Interpretations of 'culture'	144
1.2. Healing and uses of culture: some paradoxes	148
1.3. Cultural dilemmas in dealing with drinking	150
2. Contesting difference in constructions of health	157
2.1. Polarised models of health: Western bio-medicine	158
2.2. Polarised models of health: indigenous definitions	162
2.3. Conscious constructions of health	170
3. Contesting difference in approaches to alcohol	172
3.1. The impact of the North Americans: cultural and spiritual approaches	173
3.2. The impact of the North Americans: treatment centres and abstinence	176
3.3. Debating models of addiction: abstinence goals	180
3.4. Are these features specific to indigenous people?	184
3.5. Debating models of addiction: the disease metaphor	186
3.6. An Aboriginal definition of alcoholism	190
Conclusion	192
<b>Chapter Six: Broadening the Range of Interventions</b>	<b>196</b>
1. The broadening of approaches for the general population	197
2. The missing link in indigenous programs: secondary prevention	199
3. The use of brief interventions in Australia	203
4. The feasibility of brief interventions with Aboriginal drinkers	206
4.1. Feasibility: Aboriginal consumption patterns	206

4.2. Feasibility: Brief interventions and other minority populations	208
4.3. Feasibility issues associated with cultural appropriateness	209
4.3.1. The need for private and trustworthy advice	211
4.3.2. The need for assessment and evidence of harm	213
4.3.3. The need for respect and recognition of individual autonomy	216
4.3.4. The need to legitimise personal behaviour change	219
5. Which health professional could best deliver brief interventions?	222
5.1. Early reports of interest in the role of doctors	222
5.2. Evidence of late-stage intervention by doctors	224
5.3. Are doctors the best people to provide secondary prevention?	228
5.4. A critique of the role of doctors	232
5.4.1. Wariness of medical encounters	232
5.5. Should Aboriginal health workers provide brief interventions?	235
6. Impediments to implementing brief interventions for Aboriginal patients	239
6.1. Socio-economic and educational issues	240
6.2. Attitudinal, ideological and theoretical issues	242
6.3. The prevalence of social problems as a barrier	247
6.4. Logistical impediments to implementation	251
6.4.1. Time	251
6.4.2. Training	252
6.4.3. Assessment	254
7. The question of difference	256
Conclusion	259
<b>Chapter Seven: Conclusion</b>	<b>261</b>
<b>Bibliography</b>	<b>274</b>

## **ABBREVIATIONS**

AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
ATSIC	Aboriginal and Torres Strait Islander Commission
CAAAPU	Central Australian Aboriginal Alcohol Planning Unit
CDH	Commonwealth Department of Health
DAA	Department of Aboriginal Affairs
FCAATSI	Federal Council for the Advancement of Aborigines and Torres Strait Islanders
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NAIHO	National Aboriginal and Islander Health Organisation
NCADA	National Campaign Against Drug Abuse
NDS	National Drug Strategy
PER	Program Effectiveness Review
PHC	Primary Health Care
WGIP	Working Group on Indigenous Populations

## INTRODUCTION

---

The issues explored in this thesis have been prompted by a number of influences and experiences. These include ideas generated as a result of my fieldwork and research on Aboriginal health and substance abuse in various parts of Australia since 1980. This work has focussed particularly on social understandings and social controls associated with alcohol and solvent use. It made me acutely aware of the social factors restraining Aboriginal individuals from confronting those who were intoxicated, either with alcohol or with deliberately inhaled solvents. Taking heed of suggestions that anthropologists have in the past 'deflated' the problems associated with drug use, I sought to establish both an *emic perspective* and a broader view of the social and physiological pathology that can follow from overuse.

I then became intrigued with the issue of recovery from heavy alcohol use without treatment, having encountered Aboriginal people who had done so, and undertook a qualitative study of natural recovery. I was surprised by two themes which emerged: one was the extent to which people claimed that they had not received *any* intervention early in what would have been a fairly transparent progression to harmful drinking. Secondly, the most common reason for eventually giving up drinking was said by those I interviewed to be a medical condition or trauma in conjunction with a doctor's advice: that is as a result of late intervention. This research led me to the realisation that there is a large gap in present approaches to Aboriginal drug and alcohol use. There is emphasis on primary prevention and on tertiary treatment and rehabilitation, but there is very little secondary prevention activity - intervening with individuals whose problems with alcohol have started to become apparent. Putting these together (that is, the apparent influence of doctors' late advice, and the paucity of secondary prevention for Aboriginal people) led to my interest in the potential for health professionals to take a more active early

interventionist role with Aboriginal clients who are beginning to experience problems with their drinking. It became clear that the reasons for hesitation in trying these approaches with Aboriginal people were associated with the fact that such interventions are considered to be 'mainstream' and not culturally specific; that Aboriginal approaches to alcohol treatment had become fossilised and resistant to change; and that national policy-makers had skirted around the substantial alcohol problem in Aboriginal Australia, on the grounds that Aboriginal issues were separate, and Aboriginal people were 'different'.

In addition to these influences which have derived from fieldwork in Australia, I became interested in the world-wide indigenous movement. A three-month visit to Alaska and Canada as a WHO fellow in 1990 together with several subsequent visits, alerted me to the growing links between Aboriginal people in Australia and Native Americans and Canadians - and the links formed through shared attempts to deal with drug and alcohol misuse. These new associations are also part of a world-wide movement in which indigenous peoples from various countries are asserting their commonalities on a number of issues. Visiting drug and alcohol service providers in Canada, I was struck by the pervasiveness of the belief that substance abuse problems among native Canadians required long-term residential treatment oriented to abstinence. I was also struck by the absence of harm minimisation strategies, and by the view that indigenous culture was a form of treatment in itself. Since that time, a number of indigenous Canadian and American consultants visiting Australia have promulgated the view that alcohol abuse is a progressive disease for which there is a treatment but no cure. This view found a ready audience in areas of Australia where Aboriginal workers already had a fundamentalist Christian or 12 steps-based solution to problems of addiction. I began to wonder why it was that this narrow position on addiction has flourished among indigenous people.

Drawing the threads of these experiences and ideas together, I formulated two questions to be pursued in the thesis. The first question relates to the lack of strategic planning in

Aboriginal drug and alcohol interventions and particularly to the dearth of secondary prevention programs including some which are well-trialled and internationally established. This question is then: how it has eventuated that Aborigines have become excluded from national and international innovation in health - particularly in the management of drug and alcohol problems? The second question relates to the issue of cultural difference and its inhibiting influence on the dissemination of evidence-based research results and provision of services to Aboriginal people. The second question therefore asks: are mainstream models of best practice for alcohol intervention, particularly secondary prevention activities, acceptable to and feasible for Aboriginal people?

I have used a multi-faceted methodology during the research for this thesis. I have drawn on participant-observation anthropological fieldwork in South Australia and the Northern Territory. I interviewed a number of key informants on matters of history and policy development. These include several of the health professionals who had crucial influence on developments in the 1980s: Dr D. Devanesen, Dr F.S. Soong, Rev. Jim Downing, Dr Paul Torzillo, and Eileen Willis. I also observed and spoke with influential Aboriginal alcohol workers such as Les Baird, Cliff Fua, Basil Sumner, and Chicka Dixon. I drew on work undertaken in Canada (1990, 1992, 1993), which involved visits to a number of indigenous drug and alcohol programs as well as meetings with federal Medical Services Branch staff. Literature reviews for the thesis included policy documents such as the National Health Strategy, HIV/AIDS strategy, the National Alcohol Health Policy and the National Aboriginal Health Strategy Working Party report. In particular, I analysed the Hansard transcription of the 1976-1977 House of Representatives Standing Committee on Aboriginal Affairs enquiry into Alcohol Problems of Aborigines. Lastly, as part of a study into the implementation of brief interventions for hazardous alcohol use in an Aboriginal health service, I conducted interviews with patients, Aboriginal health workers and medical practitioners.

The thesis is in seven chapters. The first chapter traces the formation of identity which had its roots in the movement for equal and civil rights, through the changed atmosphere generated by the 1967 Referendum, and finally to an identity articulated as being decisively 'different': identity as an indigenous group. I show how Aboriginal activists became aware of the potential leverage to be gained through international covenants and forums and how they increasingly participated in these international meetings and met with other indigenous groups. There are two issues which are raised here as background for later chapters. One focuses on the embryonic relationship between Aboriginal health activists and the international arena, particularly the United Nations and WHO. This is a two-way exchange in which Aboriginal activists have ventilated complaints in Geneva against the Australian government (often using poor health status as an example), and in turn, principles and policies agreed to in Geneva (such as primary health care and Health for All) have become incorporated into the Aboriginal health discourse in this country. The second issue, touched on early in the thesis, is the fact that from the late 1960s Aboriginal people in this country established a pattern of contact and visitation with other Indigenous groups elsewhere. This comes to prominence in Chapter Four where I discuss the influence of indigenous Canadian and American approaches to substance abuse.

Chapter Two develops the conceptualisations of difference as articulated by Aboriginal people. Having incorporated the UN-endorsed principles of self determination and the rights of indigenous peoples as a means by which to express cultural difference, Aboriginal health activists also welcomed the WHO/UNICEF Declaration of Alma-Ata in 1978 and its endorsement of community involvement in health care. This fitted well with the ideology of the community-controlled health services movement which had begun in Australia in the early 1970s. Aboriginal people also took on the WHO definition of health (including physical, mental and social wellbeing not just the absence of disease), which they asserted was in keeping with their 'holistic' conceptualisations of wellbeing. They elaborated these holistic definitions, and positioned them in opposition to a hegemonic, bio-medical 'western' health model. This assertion of difference helped to validate the

Aboriginal community-controlled health movement which, although it was started in order to provide primary health care to people who otherwise had limited access to such services, was soon forced to defend itself against threats of mainstreaming by asserting that 'health' was conceptualised differently by Aboriginal people. Only Aboriginal health services could offer culturally appropriate treatment. Aboriginal health workers were part of this ideology too - they were 'of the people' and they offered what western-trained medical practitioners could not - inside knowledge of Aboriginal culture and concepts of health and illness.

The development of this separation on the grounds of cultural exceptionalism had some unforeseen outcomes. These are discussed in Chapter Three, where I analyse the impact of difference on the development of national policies on health, HIV/AIDS, and alcohol. Despite the forward-thinking approach and official endorsement of harm reduction policies throughout these documents, they lack substantive consideration of the needs of Aboriginal and Torres Strait Islander people. I argue that important Aboriginal health issues became marginalised and cut off from the professional input made available to the general population. The document which was intended to provide a comprehensive health policy for Aborigines emerged as the National Aboriginal Health Strategy in 1989 with little substantive guidance for implementing best practice or targeting the major causes of premature mortality. Drug and alcohol use, a key underlying factor in morbidity and mortality across the country, received inadequate consideration in this strategy.

Chapter Four examines the development of competing paradigms in the understanding of Aboriginal alcohol problems. This is done through an analysis of Aboriginal and non-Aboriginal contributions to a House of Representatives enquiry, which reveals the split between 'wet' and 'dry' approaches. This chapter shows how it came about that Aboriginal alcohol programs developed independently of both Aboriginal health services and other, State-based drug and alcohol programs, which had a number of outcomes for the range of options available for problem drinkers.

Chapter Five interrogates the propositions contained in Chapters Two, Three and Four. I return to the proposition that cultural formulae have utility in treatment regimes; to the debate on definitions of health emanating from WHO and from indigenous groups; and to indigenous definitions and constructions of alcoholism. The focus of this chapter is on the way in which difference is emphasised and similarities are ignored in three main areas: in ways of thinking about culture, in conceptualisations of health and wellbeing and in understandings of dysfunctional drinking. I propose that these conceptualisations of difference serve important political and policy-oriented functions and helped to sustain the separate resourcing of indigenous organisations.

The emphasis on cultural difference served to inhibit Aboriginal people from demanding a greater range of options for dealing with drug and alcohol misuse, and in turn marginalised them from the expertise made available to others in the Australian population. This marginalisation has been exacerbated by a kind of bureaucratic apprehension towards those said to be culturally Other. Chapter Six argues that the range of options for Aboriginal people has indeed been narrow, and that the lack of any strategic overview or mechanisms for the dissemination of innovation has meant that secondary prevention has been lacking from the armoury of possible approaches to drug and alcohol misuse. The range of brief interventions now being made available to the Australian population is an example of a secondary prevention approach found to be reasonable effective in other client groups, but which has not been disseminated to Aboriginal clients. I argue that - notwithstanding the fact these doctor-patient early interventions have not been designed to be 'culturally appropriate' or indeed with any special population in mind - they dovetail well with Aboriginal expectations of doctor-patient interactions. They may well be feasible because some of their features *are* compatible with aspects of Aboriginal 'difference', as well as being feasible - ironically - because of their similarities with other Australians. Chapter Seven concludes the thesis by reiterating the main findings and proposing some policy implications of the research.

## **CHAPTER ONE**

---

### **From civil rights to indigenous identity**

*In this chapter I trace the discovery by Aboriginal people in Australia of the value of the international arena: its principles of human rights and more particularly, the principles of self determination for indigenous peoples. These concepts came to prominence gradually in the movement to end discrimination against Aboriginal people in Australia. I describe how this movement, originally for civil and equal rights for Aborigines, became transformed into quite a different one, which stressed the right to an indigenous identity and the right to special status as an indigenous and colonised minority. During this process, Aboriginal activists were influenced by the US Black Power movement, and by access to the international arena through United Nations forums. My purpose is to document the origins of indigenous assertions of cultural difference in order to establish the background for later chapters. Throughout the development of these themes - civil rights, self determination, and difference - runs the thread of international influence. Since the time of the 1967 referendum giving the Commonwealth concurrent responsibilities with the States to legislate for Aboriginal issues, Aboriginal activists have consistently stressed their special relationship with the Commonwealth, in part because it can be held to account internationally for Australia's treatment of the indigenous population.*

#### **1. Self determination**

The principles underlying much of what has developed in terms of Aboriginal rights in this country over the past few decades have their basis in the very old idea of the 'self determination' of peoples. In its modern formulation self determination has been most

often connected with President Woodrow Wilson of the United States, who used the term in the context of the post-war peace settlement in 1918. The carnage of the First World War was blamed by the peace-making statesmen on the suppression and coercive amalgamation of European minorities. Wilson placed self determination on the international agenda and without him, the principle of self determination would not now be ratified by the United Nations (Barsh 1984; Ditton 1990; Moynihan 1994; Weaver 1993). ‘Peoples may now be dominated and governed only by their own consent’ he declared. ““Self determination” is not a mere phrase. It is an imperative principle of action, which statesmen will henceforth ignore at their peril’ (Moynihan 1994, p.79). Within months though, commentators were observing that the phrase would ‘come home to roost’ and that it was a phrase ‘simply loaded with dynamite’ (Moynihan 1994). At the time, self determination movements served to liberate distinct ethnic groups from foreign imperialism and led to more fully representative governments in former colonial states in Africa and Asia. More recently, however, self determination has become the idealistic goal of numerous indigenous groups, including ‘fourth-world’ peoples such as Aboriginal people in Australia - minority groups living within larger nation-states. Critics of the (albeit unintended) recent consequences of these movements (such as those in the old Soviet Union and the former Yugoslavia), suggest that they are ‘signs of a new and unproductive strain of self determination’ (Etzioni 1993), in which the newly independent states undermine the potential for democratic development in non-democratic countries. There has also been what one commentator described as a ‘convulsive ingathering’ of numberless groupings of people along tribal, racial, linguistic, religious and national lines (Moynihan 1994, p.65).

The term ‘self determination’ had, and still has, multiple meanings. In international law the term has come to have a technical meaning associated with the decolonisation process; it now also has a domestic meaning which is more political than legal (Brennan 1991). Associated with these multiple meanings is the debate over whether indigenous groups constitute ‘peoples’ in the international legal sense, and if so, whether they are entitled to self determination. The literature now talks of ‘levels’ of self determination, of ‘external’ and ‘internal’ self determination, with the latter being the more pragmatic and

realistic form that self determination for indigenous groups will take - in view of the fact that the majority of governments express reservations about recognising indigenous groups' rights to genuine self determination (Poynton 1996). For the purposes of this discussion, we are concerned with the domestic or 'internal' use of the term as it is used by *indigenous* minority original populations living within larger nation-states. In the context of this interpretation, the principle of self determination came to prominence in the 1970s. In 1970, the United Nations subcommittee on the Prevention of Discrimination and Protection of Minorities recommended that a comprehensive study be made of discrimination against indigenous populations. This resulted in a report by Martinez Cobo, finalised in 1984, which became a milestone in United Nations considerations of indigenous rights. The Cobo report led to the formation in 1982 of the Working Group on Indigenous Populations.

## **2. Aboriginal civil rights**

In Australia, the starting point for Aboriginal involvement in these developments lay in the movement towards Aboriginal advancement which commenced in the 1930s, many years after Woodrow Wilson's promulgation of self determination. The Aboriginal movement campaigned for *civil* rights - and the terms 'self determination' and 'indigenous' were not part of the nomenclature of the movement. However, as Heather Goodall (Goodall 1996) points out in her history of the significance of land in the political struggle of south-eastern Aborigines, Aboriginal people were not politically dormant in the years between the initial resistance to invasion and the developments of the 1930s. There were frequent and persistent demands for Aboriginal rights to land from the middle of the nineteenth century. This was because political and social authority, as well as social organisation, were as intricately linked to the land base in the south-east as they were (and are today) in Central and Northern Australia (Goodall 1996). Land, then, has long been a key issue in Aboriginal politics - and later, land and access to it came to be explicitly associated by Aboriginal people with their health status - but it was an issue which was eclipsed for a time by the struggle for equality within Australia; for rights which were comparable to those of the majority population. In short, Aboriginal people

demanded to be treated *the same* as any other Australian, at a time when they were manifestly considered to be less than equals.

The origins of the civil rights movement lay in organisations such as the Australian Aboriginal Progressive Association (1924), the Australian Aboriginal League (1934), and the Aborigines' Progressive Association (APA). The APA was founded by Bill Ferguson, an Aboriginal shearer from New South Wales and a member of both the Labor Party and the Australian Workers' Union (Horner 1994; Marcus 1978). The APA campaigned for equality of education, work and pensions, for the right to own land, and for the right to be paid in cash (not in rations). At its inaugural meeting in Dubbo in 1936 the Association passed a motion advocating full citizen rights and 'direct representation in Parliament, similar to that of the New Zealand Maoris' (Horner 1994, p.37). Australia Day 1938 (150 years after Phillip's landing at Sydney Cove in 1788) was declared by a coalition of Aboriginal political organisations as a Day of Mourning and Protest against the 'callous treatment of our people by the whitemen'. The coalition appealed for a new policy which 'will raise our people to full citizen status and equality within the community' (Horner 1994, p.199). This was at a time when Aborigines were excluded from the Commonwealth census, they were subjected to a host of social and legal discriminations under various State Acts, and most lived in squalor on the outskirts of towns and on pastoral stations. There was starvation and disease. The Depression of the 1930s meant that even more Aboriginal families lived in destitute circumstances<sup>1</sup>. Aboriginal people under the 'Dog Act'<sup>2</sup> could be penned up and shifted around like animals, liquor was forbidden, and many children of mixed descent were forcibly removed from their parents and placed in institutions (Bandler 1989; Goodall 1996; MacDonald 1995; Rowley 1974). This had the effect of making thousands of Aboriginal children 'think white, look white, act white' (Human Rights and Equal Opportunity Commission 1997; MacDonald 1995, p.xiii).

---

<sup>1</sup> Aborigines living on New South Wales Reserves for example, received only 41 pence each week for food rations, while other Australians had dole coupons which by 1936 were worth 108 pence per week (Horner 1994, p.29).

<sup>2</sup> This was how Aborigines in New South Wales saw the amendments to the Aborigines Protection Act in 1936, which gave the Aborigines Protection Board the power to confine people against their will (Goodall 1996).

There were many sympathetic whites associated with the labour movement who supported Aboriginal advancement, and the Communist Party of Australia (CPA) provided early and active support to Ferguson and the APA, and campaigned against the White Australia policy (Marcus 1978). It was also the Communists who, because of their internationalist outlook, resurrected the notion of self determination. The 1928 Soviet Comintern adopted a policy for the 'recognition of rights of all nations, regardless of race, to complete self determination' (Marcus 1978, p.147). The CPA issued a radical 14-point policy on Aborigines in 1931, including a call for the development of Aboriginal 'culture' (Goodall 1996, p.233). But these references to self determination and culture were to lie dormant and unexplored for another forty years, and the struggle in Australia was still articulated as being a struggle for civil rights and equality.

The Aboriginal civil rights movement was part of the decolonisation movements which took place in many parts of the world, particularly following World War II. In Australia, the war years had been a watershed for many Aboriginal people; some joined up, others were evacuated and lived in new regions. Peter and Jay Read observed that these years were 'the agents of a change of attitude, in outlook and expectation which were in turn the precursors of changes in the law' (Powell 1988, p.267). After the War, in 1949, Bill Ferguson seized upon the relatively new United Nations Universal Declaration of Human Rights. He made 'human rights for all people' his policy when he stood as an independent candidate for the Lawson (NSW) electorate in the December 1949 Federal election. Ferguson's biographer, Jack Horner observed,

*Out of his own personal experience bitterly protesting against the laws restricting Aborigines, he could see the real merit from the political point of view, of the Declaration of Human Rights. He seized on this document - it was only announced eleven months before ... In 1949 the declaration was popularly considered an ideal, and among the politicians it was often dismissed as both 'airy-fairy' and subversive, the brainwave of intellectuals with little knowledge of*

*real politics. For, of course, it did not admit the view that white people were superior (Horner 1994, p.166)*

In the event, Ferguson polled poorly (388 votes), and died two weeks later, bitterly disappointed. The struggle for civil rights continued through the 1950s and 1960s, with the growth of organisations such as the Aboriginal-Australian Fellowship (1956-1969) in New South Wales and numerous Aboriginal Advancement committees which were established in country towns (Bandler and Fox 1983). Two of the most significant developments of this period - although both were non-Aboriginal initiatives - were the formation of the Federal Council for the Advancement of Aborigines (FCAA) in 1958, and the 'Freedom Ride' of 1965.

## **2.1. FCAATSI**

The aim of the FCAA was to 'help the Aboriginal people of Australia become self-reliant, self-supporting members of the community'. Torres Strait Islanders were later added to its brief and the organisation became known as FCAATSI. The founding members were predominantly non-Aboriginal Australians, and these European delegates were united in their desire to end inequality and guarantee equal rights through statute. The Council was modeled in part on the Australian Council of Trade Unions (ACTU): delegates had to belong to an organisation, and most were supporters of the Labor Party or were to the left of it (Read 1990b). It was an organisation which exemplified the cooperation of black and white Australians to further Aboriginal rights. Land rights were an issue for FCAATSI, dating from its third annual conference in 1960, and were highlighted by the struggle of the people of Yirrkala in Arnhem Land, Northern Territory against the excisions from their land for a bauxite mine nearby at Gove in 1963. FCAATSI supported the submission of the petitions from Yirrkala to Federal Parliament - essentially a land claim - written and painted on bark boards (Goodall 1996; Wells 1982). There were also strong moves in New South Wales in the 1960s to have reserves handed back to Aboriginal people. However, some delegates saw the struggle for equal wages to be more important than land rights (Bandler 1989). FCAATSI and the other

Aboriginal advancement organisations all campaigned for ten years for the Referendum for a Constitutional amendment to give the Commonwealth power to legislate for Aborigines, and for Aborigines to be counted in the population Census. Their slogan was 'Right Wrongs - Write YES for Aborigines on May 27', and of course the Referendum was overwhelmingly passed on that day in 1967.<sup>3</sup> After the long Aboriginal struggle for the referendum, in the end the outcome was disappointingly humdrum, as one commentator observes (Bennett 1989). There was nothing about civil rights in the referendum. The Commonwealth was given the power to make laws on behalf of Aborigines by altering S.51(xxvi) of the Constitution, but these powers were to be concurrent with the States, which were not denied their pre-existing rights to pass laws regarding Aborigines. This meant that from 1967 onwards Commonwealth-State conflict became institutionalised and at times acrimonious when it came to indigenous matters.

However, the referendum brought about a shift in colonial relations, transforming Aboriginal politics from what had been primarily a civil rights movement to one which could consider much wider issues associated with autonomy. A few years after the referendum, community-based Aboriginal organisations were established which offered legal aid and medical care. Ian Anderson, a Koori doctor and anthropologist, interpreted the rise of a politicised Aboriginal health movement as 'driving a wedge into the political space opened by this shift in colonial relations' (Anderson 1994b, p.36).

## 2.2. The Freedom Ride

Civil rights had also been the driving force behind the 1965 'Freedom Ride' in New South Wales. The Freedom Ride was a bold attempt by sympathetic Sydney University students to draw attention to the continued existence of segregation in country towns.

---

<sup>3</sup> The passing of the Referendum in 1967 is frequently referred to as conferring 'citizenship' upon Aboriginal people, as giving them the right to vote, and making it mandatory for the Federal government to be responsible for Aboriginal affairs. The Referendum in fact did none of these things (Attwood and Markus 1997). By 1962 Aborigines, to all intents and purposes, were citizens. In 1966 the last exclusions were expunged from the Social Services Act which meant that all Aboriginal people were eligible for pensions and other social security benefits. While the referendum was supported overall, those States with the highest proportion of Aboriginal people in their populations recorded the biggest 'no' votes. 'No' votes were also plentiful in rural Australia (Bennett 1989, p.53-54).

Thirty students (including one Aboriginal, Charles Perkins) toured a dozen towns, surveying living conditions, picketing segregated facilities (such as swimming pools) and challenging retail outlets and RSL clubs that refused to serve Aborigines (Bandler 1989; Goodall 1996; Perkins 1975; Read 1990a). The posters displayed during the Freedom Ride contained slogans such as: 'Civil rights for Aborigines', 'Aborigines stand up for yourselves' (Perkins 1975:77). After only two weeks, Read (Read 1988, p.45) observes,

*Australia's press was covering the daily confrontations, Charles Perkins was a national figure and conditions in rural towns were the subject of urgent debate amongst white citizens and administrators of Aboriginal affairs.*

For the Aboriginal residents of these towns, seeing Charles Perkins, an Aboriginal, stand and argue with white officials, had a transformative effect. Older people could remember when expressions of 'insubordinate' behaviour such as this on the missions would have been met with denial of rations, loss of jobs and punishment. Lyall Munro jnr was at that time a youth in Moree, and in a later interview with Peter Read said he believed that the sheer 'guts' of the protest, and especially Perkins' role, had far-reaching consequences: 'The blacks in that town had a big influence in the future (Aboriginal) politics' (Read 1988, p.52).

By the late 1960s thinking about the 'old' civil rights movement was undergoing change. It was at this point that the idea began to form that Aboriginal people deserved an extra kind of recognition apart from equality; that as indigenous people they were *different*. In 1966 FCAATSI had added to its objectives the principle that Aboriginal and Islander people should be 'recognised as distinct cultural groups'. There was increasing acrimony about the role of whites in the organisation. According to Read a decisive turning-point took place in 1970 at the FCAATSI annual conference (Read 1990b). After visiting the United States, a white Australian delegate to the conference began to realise that the civil rights movement and the 'indigenous' movement were intertwined in Australia, when in reality they were two separate struggles:

*Civil rights ran towards a homogenous, assimilated Australia. Indigenous rights ran away from it. Pittock was one of the first white Australians to enunciate what some Aborigines had been intuitively feeling for some years, that the Civil Rights programme, embodied in such organisations as FCAATSI, might actually be stifling the growth of an indigenous identity. Civil Rights did not need an Aboriginal leadership. Indigenous rights, by definition, did* (Read 1990b, p.76).

At the 1970 conference, Pittock put forward amendments to the FCAATSI constitution that only Aboriginal or Islander people should be on the Executive and that only they should vote at General Meetings. The motion was lost, but things were never the same again. A new radical Aboriginal-controlled organisation called the National Tribal Council set itself up (with delegates wearing red headbands signifying their pride in Aboriginality) and within a few years, solely Aboriginal-controlled organisations came to prominence. The Whitlam Labor government, elected in 1972, made 'self determination,' official policy, and doubled direct Commonwealth expenditure on Aboriginal assistance programs (Gardiner-Garden 1994). As Read observes, both the civil rights movement and the post-war period of cooperation with whites ended together (1990b, p.80). There followed several years in which the influences of the US Black Power movement and an embryonic indigenous rights movement were felt and expressed by Aboriginal activists.

### **3. Black Power or Aboriginality?**

Both the press and the public had linked the NSW Freedom Ride with the Freedom Rides in the United States - although Read observes that the term is used much more commonly now than it was at the time (1988, p.45). The students distributed hand-outs of Martin Luther King's speeches and sang 'We shall overcome'. When the Tent Embassy<sup>4</sup> was erected on the lawns outside Parliament House in Canberra in 1972, this too carried echoes of the Black rights movement in the United States. Several Aboriginal activists of the 1970s displayed the insignia of 'Black Power' - Afro haircuts, black clothes, berets,

---

<sup>4</sup> The Aboriginal or 'Tent' Embassy (described by Charles Rowley in 1978 as a piece of political genius) was a parody of the formal relationships which exist between different countries.

fisted salutes. Some of the flags flown at the Tent Embassy bore African themes.<sup>5</sup> Charles Perkins (Perkins 1975, p.185) reflected on the embassy in his autobiography:

*It was a fairly new concept although it paralleled the Civil Rights Programme in the United States. The idea was not deliberately borrowed from America: it just so happens that across the world repressed groups are often forced to act along similar lines.*

On the idea of a Black Power movement in Australia, Perkins wrote:

*To my way of thinking there is no black power movement in Australia. There never has been and I do not think, while Aborigines are in it, there ever will be. Frizzy hairdos and some of the symbolism of America is borrowed by a certain minority section of the Aboriginal people. They only do that because they lack the imagination to create unique symbols of Aboriginality (Perkins 1975, p.189).*

It was not long before ‘unique symbols of Aboriginality’ and the status of Aboriginal people as *indigenous* people began to gain currency as a result of developments both at home and abroad. The significantly-named journal *Identity* came into being in July 1971. Aboriginal spokespeople began to link their struggle with that of other indigenous people, rather than with African Americans (Bennett 1989). In an article published in 1971, for example, Bobbi Sykes questioned the validity of comparisons between Aborigines and the American Negro, on the grounds that Blacks were as much interlopers in America as were Whites<sup>6</sup>. She asserted that in contrast, the ‘fate of the red man in America is alarmingly similar to the fate of the black man in Australia’ (Sykes 1971, p.31)<sup>7</sup>.

---

<sup>5</sup> See the front cover of *Identity* 1(5) July 1972, which shows two flags flying at the Tent Embassy. One bears an African-looking spear, the other features horizontal stripes in green, black and red. Thanks to Barry Cundy, AIATSIS library for this observation. The red, black and yellow Aboriginal flag was created in 1971 and was also flown at the Embassy; its existence helped to consolidate an Australia-wide Aboriginal identity.

<sup>6</sup> Bobbi Sykes is a Black Australian of American Negro heritage.

<sup>7</sup> The Aboriginal journal *Identity* carried an article by Vine Deloria Jnr which argued that the rightful land for the Black man is Africa, but that the land in America belongs to the red man. A Sioux Indian, he was involved at the time in a pan-Africanist revolutionary party which was aimed at liberating the ‘home of the black man’, Africa (Deloria 1976).

Awareness of the special connectedness shared by indigenous people was expressed by Charles Perkins in his 1975 autobiography. Perkins wrote that rather than ‘Asians’ being allowed to migrate to Australia:

*I would like to see indigenous people like Maoris, Fijians, New Guineans, Malaysians and Indonesians coming in. These people have something in common with us. They have the same sort of personality, the same feelings. We have all been suppressed people (Perkins 1975, p.193).*

Perkins had travelled overseas in 1967 to New Zealand, Hawaii, the United States and Canada. He observed that in New Zealand the white people made all the nitty-gritty decisions on Maori affairs. He met black leaders in the US including Jesse Jackson (he was unable to meet Martin Luther King) and visited an Indian reservation near Albuquerque, where Indians were bringing their own culture ‘back into force again’. He also noted that there were ‘pathetic instances of Indians trying to recapture their culture’ (Perkins 1975, p.127). In 1967 Perkins also went to Geneva as an observer to ECOSOC (UN Economic and Social Council Conference on Underdeveloped Countries). Perkins was not the only prominent Aborigine to broaden his horizons in this way. Aboriginal people increasingly made overseas visits in the 1970s, visits which undoubtedly contributed to a rising consciousness of the special qualities of being indigenous, and of the histories of invasion, colonisation and cultural destruction which they shared with other indigenous groups and people of colour in other countries.<sup>8</sup> An Aboriginal delegation of four visited Nigeria in 1974 to discuss their involvement in the World Black and African Festival of Arts and Culture, and a large Aboriginal contingent later participated in the Festival, in Lagos in 1977. Ribniga Green, from Hall’s Creek, later wrote:

*Over the five days that I was there, Hall’s Creek, the Kimberleys, Western Australia, became one with Mozambique and Angola, and I became one with*

---

<sup>8</sup> Two Aboriginal women attended the International Women’s Year conference in Mexico in 1977 (noted in the *Aboriginal Health Worker* 1(1) March 1977); Chicka Dixon visited alcohol programs in the US and Canada in 1977. Alick Jackomos visited Indian reservations in the US in 1978 (noted in *Identity* July 1978)

*Stevie Wonder and the Coloureds from Great Britain. For that period of time we were all of one mind and one spirit ... Greater numbers of people overseas are now learning at first-hand from Australian Blacks of conditions here, past and present; of the genocide of Tasmanian Blacks; and others express surprise even to hear that such a race as ours exists on this continent (Green 1980, p.388)*

Aborigines were also learning the art of political strategising at an international and not just a domestic level: there were visits to lobby overseas, and left-wing activists made trips to China and Libya<sup>9</sup>. In 1976 Charles Perkins invited black world heavyweight boxing champion Muhammed Ali to Australia, 'to see the plight of the Aboriginals'.<sup>10</sup>

These developments occurred against a backdrop of political change in Federal Australian politics. Early in 1972 (before the Labor election win), the Coalition Prime Minister William McMahon had set out a Commonwealth policy in Aboriginal Affairs which ended assimilation. As Frank Brennan notes (Brennan 1991). Aborigines came onto the political agenda as all parties for the first time made commitments to their welfare, advancement and rights.<sup>11</sup> By the end of 1972 and the election of a Labor government, the policy of self determination was implemented, which seemed to suggest a real freedom for Aborigines to control their own destinies, although the political reality was that 'governments were reluctant to take the step that would breathe meaning into the concept' (Bennett 1989, p.28). A subsequent Liberal Coalition government under Malcolm Fraser was elected in 1976, and instituted a diminished version of self determination, calling it 'self management'. It attempted to hand some responsibility for Aboriginal issues back to the States. The Coalition government issued a statement in

<sup>9</sup> Kath Walker went to London in the early 1970s to negotiate with Lord Vestey on behalf of the Gurindji (*Identity* 3(11) 1979:16). The first Aboriginal delegation to China was in 1972. Nine people went, including Chicka Dixon and Gary Foley. Dixon recalled that while Qantas refused to fly them to China, they were given the 'red carpet treatment' once they were there (Dixon, Pers.comm.21/4/97). For accounts of this visit, see *Identity* July 1973 and July 1974 (Harris 1979). A 1979 edition of *Identity* (3(11):19) carries a photograph of Gary Foley and Bruce McGuinness visiting Marx's tomb in London.

<sup>10</sup> 'Perkins seeking Ali visit' *The Daily Telegraph* 13 May 1976.

<sup>11</sup> Charles Rowley observed that an increasingly well-educated Aboriginal elite which had made contacts in Africa and the United States was unlikely to accept vague promises of some future equality. He urged the government to facilitate rather than oppose Aboriginal political groups or risk Aboriginal recourse to 'black power,' (Rowley 1973).

1975 declaring ambiguously that it was committed to the principle that ‘all Aborigines and Torres Strait Islanders should be *as free as other Australians* to determine their own varied futures’ (Viner 1978, p.3442, emphasis added).

In a sense, it was too late for the Coalition government to try to retreat from the radical implications of ‘self determination’ to the more restrained notion of ‘self management’. The phrase ‘self determination’ had already taken off and began to be used by Aboriginal organisations and individuals as part of their political strategising. When the Central Australian Aboriginal Congress was formed in 1973, it was said to be an ‘expression of Pan-Aboriginalism and Aboriginal Self Determination’. Congress later became a fully-fledged Aboriginal medical service. Congress demanded recognition for Aboriginal Australians as a distinct and viable cultural group, compensation for dispossession, the right to self determination and autonomy, and entitlement to special assistance in promoting social, cultural, economic and education development. The organisation announced that Aboriginal identity could be claimed by both ‘full-blood’ and ‘part-blood’ people and that they all had a right to ‘maintain a continuity with their Aboriginal culture and identity, and to assert their “Aboriginality”’ (Perkins 1974, pp.27-28). By the early 1970s the special qualities of Aboriginality were being stressed.

#### **4. Utilising the court of world opinion**

As the statement from Congress reveals, not only was there a growing recognition among Aborigines of their status as indigenous people, there was also the realisation that as an indigenous ‘Fourth World’ population<sup>12</sup> their status implied an entitlement to certain rights (Beckett 1985). Aboriginality is a refined claim to distinctiveness based on a status as the original occupants of a place, and on historical experience: a form of ethnonationalism (Levin 1993). Like other Fourth World groups, Aboriginal people in Australia correctly perceived that governments are sensitive to criticism about their treatment of former colonies, or of colonised peoples, and have used what Jeremy

---

<sup>12</sup> ‘Fourth World’ populations are distinguished from other ethnic minorities in that they are the original inhabitants of lands that are now part of larger nation-states (Dyck 1985). The term came to prominence in the 1970s (Green 1980).

Beckett terms the *politics of embarrassment* to some effect in international forums (Beckett 1985, p.98).<sup>13</sup> Their use of moral arguments supporting the rightfulness of claims on governments have, Beckett suggests, allowed Fourth World groups to rise above their powerlessness and small numbers (in Australia, only 2 percent of the population). Calling upon the court of world opinion not only encourages governments to demonstrate generosity and concern over indigenous welfare and rights, it also enables those governments to demonstrate their humanity in the eyes of the international community. There was a dawning recognition among Aboriginal activists that because Australia is a signatory to a variety of international protocols and covenants, the international arena can be used to air complaints about Australia's domestic performance in indigenous affairs.

As mentioned earlier, the potential for the United Nations to have a relevant role in the Aboriginal struggle had been noticed by Aboriginal rights campaigner Bill Ferguson in 1949 when he utilised the UN Universal Declaration of Human Rights. Nineteen years later, in 1968 at a FCAATSI annual conference, a delegate had reminded the audience that the International Labor Organisation (ILO) Convention 107 stated a right to the protection of indigenous and other tribal and semi-tribal populations (Bandler 1989). With the growth of Aboriginal political consciousness in the 1970s (and the establishment of Aboriginal Legal Services together with the availability of sympathetic lawyers), came an increased awareness that Aboriginal frustrations with domestic governments could be taken to the United Nations. In 1971 a plea was made to the UN by the Aboriginal Advancement League of Victoria for the recognition of land rights (Green 1980, p.391). The National Aboriginal Congress<sup>14</sup> decided on a program of international

---

<sup>13</sup> This phrase has become increasingly apposite. A speech by Mick Dodson, the Aboriginal and Torres Strait Islander Social Justice Commissioner, in July 1995 stated that Aborigines were about to use international fora to embarrass the government into addressing indigenous concerns. The *Sydney Morning Herald* (29/7/95:8) headlined the story 'Aborigines ready to embarrass Govt on rights'. Jack Waterford had observed in 1979 that the activities of Aboriginal activists overseas had made the Australian government 'very nervous', prompting Foreign Affairs to appoint a staffer to deal with the ensuing queries (Waterford 1979).

<sup>14</sup> The National Aboriginal Congress was an interim body existing in the time period between the National Aboriginal Consultative Council (NACC) which had been established by the Labor government (1972-1975), and the National Aboriginal Conference established under the Liberal Coalition government in 1977. These were the first national Aboriginal bodies established explicitly as policy advisory bodies to the Aboriginal Affairs portfolio (Bennett 1989; Weaver 1993).

representation, and in 1976 announced its intention to give proof to the UN of the oppression and despair of Aborigines who had the 'highest infant mortality rate in the world'. Delegates delivered a statement to the Governor-General to this effect.<sup>15</sup> In 1980 the NAC sent a delegation to the UN sub-commission on Elimination of Discrimination and Protection of Minorities in Geneva, to raise the Noonkanbah issue.<sup>16</sup>

Aboriginal interest in a solely *indigenous* peoples' forum (rather than the UN as a whole) was sparked in 1981 when an international non-government organisation, the World Council of Indigenous Peoples, held its third Council meeting in Canberra (Brennan 1991).<sup>17</sup> The Council had consultative status to UN bodies and provided a network and a voice for indigenous groups. From 1982, the more official UN Working Group on Indigenous Populations was established, which came to provide a regular forum for representatives to meet in Geneva. The WGIP is empowered to make yearly reports which it is proposed will form the basis of a declaration of the rights of indigenous populations. In its first few years, the WGIP participants were predominantly from North America, Australia and Central and South America; by the late 1980s indigenous groups from West Papua, the Moluccas, Burma, India, Hill Tribes from Thailand and Bangladesh and the Ainu in Japan were attending. The Working Group is open to any group that may wish to speak (Gray 1995; Kingsbury 1995).<sup>18</sup> The first official Aboriginal representation to this forum was in 1983, when an Aboriginal delegation organised by the National Aboriginal and Islanders Legal Services Secretariat (NAILSS) attended the second session of the WGIP (Aboriginal Law Research Unit 1985;

<sup>15</sup> 'Aborigines will appeal to UN', *Identity*, April 1976:16

<sup>16</sup> The Noonkanbah issue was a confrontation which took place 1978-1981 between the Aboriginal owners of a cattle station in Western Australia and the mining company CRA, drilling for oil. The Aboriginal community blockaded the station, but mining trucks under police escort eventually broke through. The WA government was criticised by the UN for its actions following the Geneva delegation.

<sup>17</sup> See also 'World Council of Indigenous Peoples Conference - April 1981', *Identity* 4(2) 1981:20. Mick Miller, then the Chairman of the North Queensland Land Council, had attended the 1977 meeting of the WCIP in Sweden (Harris 1979).

<sup>18</sup> This flexible approach has been necessary in part because there is ambiguity over what the term 'indigenous' actually means and the WGIP Draft Declaration on the Rights of Indigenous Peoples does not contain an explicit statement as to the meaning of the term. Even in the 1990s, WHO and UN workshops still actively debate usage, sometimes agreeing to 'self-identification' as being a fundamental criterion. ILO Convention 169 provides a definition which includes as indigenous, peoples in independent countries who are descended from the populations which inhabited the country or part of the country at the time of

Macdonald 1993). Also attending were representatives of the Federation of Aboriginal Land Councils. In the following year, 1984, Aboriginal delegates attended the fortieth session of the United Nations Commission on Human Rights, at which they made representations on the continuing dispossession and destruction of Aboriginal people as a result of European settlement. As a result, the Aboriginal Law Research Unit (Aboriginal Law Research Unit 1985, p.2) reported that

*Aboriginal participation in the United Nations process is definitely raising the profile of [indigenous rights] generally. Aboriginal representatives are able to see that the UN is not a mystical foundation of justice. They are exposed to the reality of the UN as a complex political bureaucratic machine which moves very slowly.*

More critically, Brennan (1991) noted increasing Aboriginal frustration at the endless redrafting, and the drawn-out discussions of the meanings of words: the ‘clouds’ floating above what is really happening on the ground in Aboriginal communities. Nevertheless, Aboriginal groups have been represented at the WGIP every year since then; their contributions are now officially published by the Aboriginal and Torres Strait Islander Commission (ATSIC) each year.<sup>19</sup> ATSIC now takes the responsibility of ensuring that Aboriginal and Torres Strait Islander perspectives are represented at international forums and maintains an international issues section within its legal aid branch. Despite the slow progress of the work of the WGIP and observations that much of what takes place is, in effect, insubstantial (Brennan calls it ‘clouds floating above Geneva’), the Draft Declaration on the Rights of Indigenous Peoples is afforded considerable significance by the numerous Aboriginal delegates who have attended the meetings in Geneva. The Draft Declaration demonstrates how far the thinking of indigenous groups has developed, for it speaks not of equality and identification with others but of *difference*. The first paragraph

---

conquest, and who retain some or all of their own social, economic, cultural and political institutions (Kingsbury 1995; PAHO 1993; Waterford 1979)

<sup>19</sup> ATSIC was formed in 1990 and is a national organisation representing Indigenous people which also administers and disburses Federally-derived funds.

of the Draft Declaration on the Rights of Indigenous Peoples (as at the 11th session of the WGIP) states:

*Affirming that indigenous peoples are equal in dignity and rights to all other peoples, while recognising the right of all peoples to be different, to consider themselves different, and to be respected as such (Aboriginal and Torres Strait Islander Commission 1994a, p.95)*

## **5. Aboriginal health in the international arena**

In 1978 two UN bodies, the World Health Organization and UNICEF, held a joint conference at Alma-Ata in Russia at which health was described as a human right to which all people were entitled. The Declaration made at the conference stressed the role of primary health care, and the need for community participation and local self determination in health. The emphasis in primary health care is on prevention, health promotion, and the provision of *basic* health care. While the implication of this is that high-cost, high-technology specialist medicine is de-emphasised, the Declaration also states that health care must be ‘scientifically sound’ (Department of Community Services and Health 1988, p.40). The Alma-Ata conference succeeded in placing health on world and national agendas, and its progressive statements on the role of ordinary people in determining priorities and influencing service delivery were to have a profound influence on the Aboriginal health movement. The Alma-Ata Declaration (with its broad appeal for local participation and self determination), provided Aboriginal health activists with a benchmark and a philosophy, formulated in a prestigious and widely publicised international forum, which could be used in Australia to argue for greater Aboriginal control over services and health policy.

In addition to these philosophical and policy influences emanating from Alma-Ata and WHO, the international stage provided an overtly political arena for Aboriginal activists to publicise the health status of their people, and the appalling gap between Aboriginal and non-Aboriginal life expectancy, thus exposing Australian governments to

international scrutiny.<sup>20</sup> Although the early delegations to forums such as the WGIP were focused primarily on land rights, health issues later became a regular part of Aboriginal presentations to the Working Group. They associated land rights, human rights and self determination, with health.<sup>21</sup> In 1992 (ten years after the WGIP first commenced), the Aboriginal delegation argued in Geneva that welfare programs including health, housing and legal services are a fundamental right and should not be seen as 'special' programs for Aboriginal people. They argued that these programs should be financed directly from government to community-based organisations (Aboriginal and Torres Strait Islander Commission 1992). In 1995 the Aboriginal and Torres Strait Islander Social Justice Commissioner's second report focused on Aboriginal health. The report also stressed that indigenous people have 'inherent rights' which should not depend upon the charity of the non-indigenous society. Commissioner Dodson utilised the work of an American health researcher Stephen Kunitz (Kunitz 1994), which stressed Australia's particularly 'dysfunctional' form of federalism as applied to Aboriginal health policy. Kunitz' work also showed that the life expectancy of Australian Aborigines was lower than that of other comparable Fourth World peoples - and Dodson cited this to fuel accusations that Aboriginal human rights to health were being breached.<sup>22</sup> Invoking international human rights obligations in a Human Rights and Equal Opportunity Commission media release in March 1995 Commissioner Dodson stated that:

*The continued inability of governments to ensure indigenous Australians' basic human right to health is in breach of Australia's international obligations... (He) warned that indigenous Australians could well make use of domestic and*

---

<sup>20</sup> It must be pointed out, however, that some Aboriginal delegates presented incorrect data to this forum. In 1992 one youth delegate asserted that average life expectancy was 39 years (Allam 1993). Average Aboriginal life expectancy at birth is 54 years for men and 61.6 for women (Kunitz 1994).

<sup>21</sup> However, the early Aboriginal delegations to Geneva were primarily land rights activists, rather than representatives of the Aboriginal health movement. In 1994 (amid a surge of publicity about Aboriginal health administration and native title) the issue of the link between land rights and health re-emerged and was debated (Flick and Nelson 1994).

<sup>22</sup> Analysing the adoption or rejection of new research, by individuals and organisations, Kunitz and Levy later used this research and reactions to it as an example. They observed that it was widely cited by Aboriginal health activists and human rights spokespeople to support arguments for further funding and greater involvement of the Australian Federal government in Aboriginal health. They suggested that the research was adopted because its findings were congruent with what many Aboriginal activists and Commonwealth bureaucrats already believed (Kunitz and Levy 1995).

*international mechanisms to bring the Australian Government into account for its failure.*

The association between self determination and health is now considered to be self-evident by Aboriginal activists and progressive governments. For example, self determination - or rather, the lack of it - has been explicitly linked by the National Aboriginal and Islander Legal Services Secretariat (NAILSS) to Aboriginal deaths in police and prison custody (Pritchard 1990). The alarming number of such deaths prompted a Royal Commission investigation which reported in 1991 (Johnston 1991).

Apart from raising health issues at official forums such as the UN, in the 1970s and 1980s Aboriginal people had made other international links in the field of health: they utilised study grants to travel overseas, attended conferences, and observed grass-roots health programs in developing countries. At an Aboriginal Health Workers' conference in Alice Springs in 1980, it was agreed that more visits overseas (rather than to hospitals down south) would help to 'get ideas from other people and other places' (Northern Territory Department of Health 1980, p.11). As a result, Aboriginal people in Australia began to be directly exposed to the progressive, community-based practice of primary health care which was being implemented in developing countries - the practice which had been endorsed in the Alma-Ata Declaration.<sup>23</sup> These programs shifted attention away from the supremacy of the fully medically-trained doctor towards the role of local people.

## **6. Faith in the Commonwealth?**

It is important to point out that the operation of Australian federalism has a particular and peculiar significance when it comes to indigenous affairs - indeed it has a particular

---

<sup>23</sup> Elkin mentions that an Aboriginal man visited Noumea as early as 1957 and heard about the existence of native medical assistants there (Elkin 1977, p.181). Elcho Island Aboriginal health workers on a church-based visit to the Phillipines in 1981 met David Werner there coincidentally, and attended a workshop he conducted on 'Primary health care and human dignity' (*Aboriginal Health Worker Journal* 1982 6(4):11-20). Aboriginal health workers visited Papua New Guinea in 1980 (Northern Territory Department of Health 1980), and in 1982 two Aboriginal health workers from Milingimbi who observed health care in Papua New Guinea were struck by the fact that Papua New Guineans were trained as nurses, (not as health

significance to health policy and programming. Federalism in Australia is marked by a perpetual distinction, and a deep rift, between the two major political parties. Each takes a different ideological and philosophical approach to it, with the Labor party calling for national planning of economic, social and cultural developments, and the Liberal/Coalition arguing for regionalism and devolution to the State and Territory governments. Changes in national governments bring about changes in the emphasis on 'State rights'. Despite the Commonwealth having a legitimate interest in Aboriginal Affairs (as a result of the constitutional change brought about by the 1967 referendum), the State governments have always considered themselves to be responsible for all health matters, and for many other service-provision functions affecting Aboriginal people. Aboriginal people however, have continued to stress their special status and as a corollary, the special relationship they have with the national government of the country, the Commonwealth. The belief that there would be a special relationship with the Commonwealth sprang from the great hopes and expectations raised by the campaign for the 1967 referendum - the Federal government, rather than the States, was to be the saviour of Aboriginal rights and put an end to discrimination. Unlike the United States, where treaties and trust responsibilities made Indian affairs squarely a Federal responsibility, Aboriginal affairs in Australia were exclusively a State responsibility until 1967. The grossly discriminatory State laws which affected indigenous people differed from State to State, as Chicka Dixon pointed out at the time of the referendum in 1967:

*For too long the Constitution has been a handy excuse for the Commonwealth Government to neatly sidestep its responsibilities to Aborigines. Once this excuse is removed we expect the Commonwealth will finally make a man of itself and accept its responsibilities. We want a clear national policy towards Aborigines - and an undivided one. At present we are subject to different laws in every State. Few white people realise that I, as an Aboriginal, would break the law somewhere by merely moving around the country as an ordinary citizen ... There is another important point about Commonwealth responsibility for Aborigines.*

---

workers) and had the same qualifications as expatriate nurses (*Aboriginal Health Worker Journal* 1982 6(3):26-31).

*Responsibility in Canberra means responsibility where the money bags are*  
*(Attwood and Markus 1997, p.115-6).*

So for many Aboriginal people, the referendum held out hopes that the Federal government would flex its muscles on Aboriginal issues, over-riding the States. The Federal government was of supreme importance because it could (in theory) deal with State-based discriminations and disburse large amounts of money, and because it - not the State governments - is a signatory to the international human rights agreements to which Aboriginal activists turned. Only the Commonwealth government is recognised by the international community as having 'international legal personality'; it, not the States, has the executive power to enter into treaties under s.61 of the Constitution (Senate Legal and Constitutional References Committee 1995). Unlike Canada and the United States, neither the colonial government nor the modern Australian government ever entered into an internal treaty with its indigenous people, so this avenue of leverage is denied them. Partly for this reason the international arena was, and continues to be, a focus for the aspirations of Aboriginal activists, as it offers great potential for the expression of Aboriginal grievances. Both at the time and since, though, the referendum itself acquired a significance far beyond the meaning of the actual constitutional changes contained in it. Its significance is a matter of interpretation and perspective which are subject to change over time, as Attwood and Markus point out (1997). The hopes and aspirations projected onto it ebbed away immediately after the referendum as the Coalition government of the day prevaricated, and it was not until 1972, with the new Whitlam Labor government, that Commonwealth action began in earnest by establishing a Ministry of Aboriginal Affairs (Attwood and Markus 1997; Bennett 1989). Whitlam acted decisively in keeping with Labor's centralising philosophy, and directed funds straight to Aboriginal-controlled organisations. Nevertheless the dominant role of the States in Aboriginal affairs has never been seriously questioned. In the ensuing twenty-five years, it has become even clearer the responsibility is indeed *concurrent* between the Commonwealth and the States, with the result being that neither has assumed full responsibility.

This concurrent role has particular significance in Aboriginal health, for the provision of health services for all Australians has always been largely a State matter. The States had resisted the formation of a Federal department of health in the early years of the twentieth century, and it was only the issue of quarantine and the 1918 influenza pandemic that forced the issue (Cumpston and Lewis 1989).<sup>24</sup> As Kunitz has pointed out, having the States/Territories responsible for the health and welfare of Aboriginal people is akin to leaving the fox to guard the chickens, in view of State government vulnerability to economic pressures from land, mining and property interests (Kunitz 1994).<sup>25</sup> Even under Labor governments, the Commonwealth found it difficult to negotiate the necessary financial and political cooperation of the States to bring about the urgently-needed changes in Aboriginal health status.<sup>26</sup> The Commonwealth directs considerable grant monies to the States for the delivery of health services to all Australians, including indigenous people, but these grants suffer from lack of transparency, and the consequent inability of the Commonwealth to ensure that monies are spent in their intended manner (Bennett 1989; Gardiner-Garden 1994; House of Representatives Standing Committee on Aboriginal Affairs 1993; Thomson 1984). Aboriginal people have long had a problematic relationship with the state-run so-called 'mainstream' system (the hospitals and general community health care services), finding it alienating, disempowering and discriminatory. Some States (Queensland, for example) persisted with assimilationist policies, ignoring broader policies of self management or self determination. Others failed to identify indigenous people in their record-keeping systems. Because Aboriginal health program and resource delivery is part of the broader Australian health care system, the Federal structure of the health system continues to have important implications for the development of effective strategies to deal with Aboriginal health (Anderson 1997a). In this context, some commentators have described Aboriginal health as being 'hostage' to Australian Federalism (Bartlett and Legge 1994).

---

<sup>24</sup> The Federal department of health was finally created in 1921 (Cumpston and Lewis 1989).

<sup>25</sup> Added to this list could go wine-growing interests. In 1989 the Federal government bowed to pressure from alcohol industry lobbyists and to the fact that the then Minister for Health came from South Australia (a prime wine-growing state), and diluted what was to have been a radical National Health Policy on Alcohol (Elvy 1989; Hawks 1989).

<sup>26</sup> Indeed only in 1996 and 1997, thirty years after the referendum, has the Commonwealth brokered 'health partnerships' with the states.

Nevertheless, Aboriginal health activists continued to stress their relationship with the Federal government, primarily because the Aboriginal community-controlled health services received funding directly from the Commonwealth government, and via direct grants from the Commonwealth to the States from the 1970s onward. The Commonwealth administrative apparatus administered this funding through the Department of Aboriginal Affairs (DAA) until 1989, as the Department of Health had only a peripheral involvement in the administration of Aboriginal health programs. However early in 1990 a new statutory body came into existence called the Aboriginal and Torres Strait Islander Commission (ATSIC), which inherited the former department's role in Aboriginal health. The ATSIC organisation has a two-tiered structure with a Board of Commissioners and elected Regional Councils representing Aboriginal and Torres Strait Islander communities, and a bureaucracy with a central Canberra office and State and regional offices. Despite being hailed as a 'major step towards self determination for Aboriginal and Torres Strait Islander peoples' (Aboriginal and Torres Strait Islander Commission 1994a, p.38), ATSIC is a Commonwealth agency peripheral to the Commonwealth apparatus. Ian Anderson points out that 'ATSIC had little leverage with the central agencies of Treasury and Finance' (Anderson 1997a, p.133), and even has a limited and indirect association with the Minister for Aboriginal Affairs. One Minister observed: 'I, as Minister, have only limited powers to issue "general" directions to ATSIC and even these can then be challenged by the Parliament,' (Aboriginal and Torres Strait Islander Commission 1994a, p.38). He saw the arrangement as a transfer of ministerial decision-making to the elected representatives of indigenous people.

After four years of ATSIC administration of Aboriginal health resource allocation, the Aboriginal health movement became dissatisfied with the quality of decision-making, and the level of political and financial leverage ATSIC was able to negotiate with governments. The 1994 annual report of the Aboriginal and Torres Strait Islander Social Justice Commissioner was largely devoted to a critique of government and ATSIC failings in Aboriginal health. The report contained a 'health map' which was an attempt to draw up the complex and convoluted arrangements for Federally-funded programs for the indigenous component of the Australian population - at the time 1.6 percent. 'The

need for leadership by the Commonwealth has never been clearer,' Commissioner Dodson stated (Dodson 1995, p.125). Faith in the Commonwealth thus came to a head again in the mid 1990s when, after considerable lobbying, ATSIC was relieved of the responsibility for national oversight of Aboriginal health. The responsibility was redirected to a new, substantially-staffed office which was firmly located in the Commonwealth Department of Health. This meant that Aboriginal health issues would be in the portfolio of a senior Cabinet Minister, and would be in a position to access a larger share of the \$16 billion <sup>27</sup> spent on health services by the Commonwealth. Estimates in 1996 were that spending on indigenous health constituted 1.25 percent of this amount.

## Conclusion

In this chapter I have shown that - once the movement for Aboriginal civil rights was reconstituted as a movement emphasising special indigenous rights - Aboriginal activists came to seek outside international support in, and recognition of, their struggle for domestic self determination. They also sought affirmation of their right to cultural difference from the majority population. The country's Federal government was and is important in this process, for it is the government held accountable internationally for its treatment of indigenous people. The Federal government also became the focus of Aboriginal attention in their attempts to gain an equitable share of the resources needed for the improvement of Aboriginal health, and in attempts to persuade the State and Territory governments to be more transparent in their accounting for Commonwealth monies intended for indigenous programs. In the next chapter, I take up the theme of international influence, and show how it came to affect thinking about Aboriginal health as a result of the Alma-Ata Declaration, and as a result of the ideals of health which were promoted by the World Health Organisation.

---

<sup>27</sup> 1993-4 Budget figures estimated health expenditure to be \$16.3 billion.

## CHAPTER TWO

---

### WHO and constructions of difference in health<sup>1</sup>

*Just as the movement towards Aboriginal rights was underpinned and influenced by international principles and participation in international dialogue, so too was the movement to improve Aboriginal health status. An underlying influence on debates over Aboriginal health and on the delivery of health services to them over the last 25 years has been WHO's promotion of community involvement in health care as articulated in the Alma-Ata Declaration of 1978. This was partly responsible for consolidating the position of Aboriginal community-controlled health services and also for the emphasis given to the important place of Aboriginal health workers in the improvement of Aboriginal health. Ratification of the broad WHO definition of health at Alma-Ata also provided a vehicle for Aboriginal health activism, allowing for the development of purely 'Aboriginal' definitions of health. In this way, Aboriginal people could align themselves with an international movement while simultaneously stressing their own cultural difference. This chapter explores how the concept of indigenous difference has been elaborated and expressed in the Aboriginal health debate.*

#### 1. The need for Aboriginal Health Services

In the new atmosphere generated by Aboriginal activism and more progressive policies towards Aboriginal issues, Aboriginal community-controlled health services were developed from 1971 onwards because Aboriginal people were simply not able to access the health services which were available to other Australians. The work of Max Kamien provides a graphic illustration of the situation which helped to inspire the formation of

---

<sup>1</sup> Some of the ideas in this chapter have been published as 'WHO's definition? Australian Aborigines, conceptualisations of health, and the World Health Organisation' (Brady, Kunitz and Nash 1997). I am indebted to Stephen Kunitz for lively discussion on these issues.

these independent services. In 1971 Kamien worked as a doctor in Bourke, New South Wales, a country town of about 3000 whites and 730 Aboriginal people. Bourke was, he said, better endowed with health services than any other rural town of comparable size. In 1971 he counted 65 health personnel in the town, 10 visiting consultants, and a team of visiting specialists who came once a year. Despite this extraordinary array of medical professionals, the Aboriginal infant mortality rate between 1967 and 1971 was 88.2 per 1000 compared with a non-Aboriginal infant mortality rate of 9.4 per 1000. Infant mortality, while not being wholly preventable is one in which primary health care and medical intervention can make a difference. (Kamien 1975a, p.6-11).<sup>2</sup> Kamien's findings show, quite simply, that primary health care was not reaching the Aboriginal population and that the presence of this phalanx of medical practitioners was having no impact on their health.

In the 1960s and early 1970s, as Kamien demonstrated, Aborigines, like other poor Australians, were dependent on public hospital out-patient departments for free primary medical care if they lived in urban or rural areas. Receiving health care in this way subjected Aboriginal people to gross racism and discrimination, for there were often segregated waiting rooms, refusals of treatment, and even special crockery and cutlery marked 'Abo' (Saggers and Gray 1991; Sibthorpe 1988; Speare and Kelly 1991). Private practitioners gave free medical care to Aborigines as a 'private charity' which reflected each practitioner's level of concern for the poor (Kamien 1975a). Anderson describes this situation - in which Aborigines were treated on the hospital verandah, or by an often resentful general practitioner - as forcing Aborigines to interact at the 'margins of the system'. Knowing that they were often resented and patronised, Aboriginal people were hardly likely to make appointments for routine check-ups; they tended not to seek care until they were critically ill (Anderson 1994b) (Koori healing 1994a). As Waterford (Waterford 1982, p16) explained,

*It was not simply that few Aboriginal hands were involved in the actual delivery - although this was a marked feature. It was that the services were to the blacks, but in no way of them. Racism, hostility, and simple*

---

<sup>2</sup> The highest IMR now is in the Northern Territory, 26.9 per 1000 live births.

*ignorance on the part of the often strangely-dedicated deliverers rendered any ameliorations they were able to offer almost completely useless - even when the objects of their attention bothered to come for attention. Most often they would not [come] at all ...*

If Aborigines resided in remote regions, they received basic health services from nursing sisters in government settlements, slightly better services from mission-based sisters (who tended to stay for longer periods) or from occasional visits by the Royal Flying Doctor Service. Dr Kerry Kirke, who in 1969 was in charge of rural health in the Alice Springs region, denounced services at the time as 'grossly inadequate' and 'shameful', with only one doctor and three nurses serving a population of 8,500, half of whom were under 15 years of age (Kirke 1969). Aboriginal life expectancy in Central Australia in 1972 was 40.2 years at one year of life (Couzos and Murray 1999, p.12). At the same time, Middleton and Francis (Middleton and Francis 1976) commented, with some restraint it seems, that the Western medical care for the Aboriginal people at Yuendumu and at Alice Springs hospital was not provided under 'optimal conditions'. Hard-hitting observations were made by Tatz about the quality of such services and the departmental wranglings within the Northern Territory (Tatz 1972).

## **2. The development of Aboriginal health services**

In this situation, Aboriginal community-controlled health services developed in the early 1970s (initially in urban areas) out of sheer necessity, in order to make primary health care services accessible to Aboriginal people who were otherwise not receiving *any* health care until they were seriously ill. These started initially with the help of some dedicated medical practitioners, volunteer staff and community donations and subsequently received funds from the Commonwealth.

## **2.1. Community participation and control**

The first Aboriginal Medical Service, in Redfern, Sydney, received some Federal funding in November 1971, despite the opposition of the New South Wales State government. This service was an entirely Aboriginal concept, neither instigated nor supported by any section of government or the health bureaucracy. It was (and is) free, accessible and local (a shop front in the middle of Redfern); it was governed by an all-Aboriginal elected board of directors and employed Aboriginal staff. In Melbourne, the Victorian Aboriginal Health Service was established at Fitzroy in early 1973, and this was also a community rather than a government initiative. Staff worked on a voluntary basis before receiving an initial grant of \$57,000 from DAA (Nathan 1980). A VAHS paper from 1978 described the service:

*A community-based health programme recognises that the health problems of any community are interrelated with the economic and cultural problems of society. Health is thus seen as only one component of the overall development of the community. Rather than emphasise the acquisition of high quality sophisticated medical skills and treatment for the community, priority is placed on using health as a way to motivate people to improve their standard of living and their quality of life ... Physical health becomes not only the main concern but also mental and social health as well. The total well-being of man and his community is taken into account (Nathan 1980, p.22).*

It is notable that this very 'community based' infrastructure *predated* the Alma-Ata Declaration recommending community participation in health by several years (Fagan 1991). Very much in keeping with the spirit of the Alma-Ata Declaration of primary health care (when it emerged), Aboriginal medical services not only provided access to medical consultations, they facilitated a range of community development and outreach programs (Reid 1982).<sup>3</sup> However, as I discuss shortly, in later years Alma-Ata and WHO

---

<sup>3</sup> In 1974 the Redfern Aboriginal Medical Service had a fruit and vegetable run, followed up malnourished patients, provided vitamins, clothing and blankets as emergency relief to rural patients, and provided aid when other welfare agencies were closed (Foley 1975)

came to have increasing ideological significance for the AMSs and for the Aboriginal health activists who lobbied continuously for their ongoing survival.

AMSSs increased in number and continued to be primarily funded directly from the Federal Department of Aboriginal Affairs (DAA) by-passing the States, during the Fraser Liberal government from 1976. In the 1979-80 financial year, for example, Commonwealth grants-in-aid (via DAA) to AMSSs totalled \$2.9 million (Department of Prime Minister and Cabinet 1980). By 1978 there were eleven urban and three rural AMSSs.<sup>4</sup> However there was no coherent plan to establish AMSSs strategically across the country, which would have enabled a variety of Aboriginal populations living in different circumstances to have equal access to them. Grants were allocated on the basis of requests from organisations which demonstrated a capacity and established a need rather than on a population basis (Department of Prime Minister and Cabinet 1980) - in other words, the services were developed in an ad hoc manner.

One explanation for this lack of strategic planning for AMSSs (an explanation which was never made explicit), is that the Commonwealth never intended that AMSSs would become permanent separate services, but rather that they were a step towards integrating Aborigines into mainstream health services. As recently as 1988 for example, the Federal Department of Aboriginal Affairs (DAA) asserted that Aboriginal medical services would ultimately be mainstreamed (Baker 1989; Sibthorpe 1988). So it was that official policy attempted to ward off the proliferation of separate Aboriginal-run services; by the early 1980s less than five percent of national spending on Aboriginal health went to AMSSs. This official antipathy caused immense bitterness and mistrust on both sides. By resisting their formation, and impeding the smooth development of the services, different governments merely succeeded in accentuating the politicisation of the Aboriginal health lobby. Providing services aside, the AMSSs fulfil explicit and implicit purposes in the form of political activism and lobbying, and their separatist presence represents a constant challenge to the principles of 'mainstreaming' and integration

---

<sup>4</sup>These were: Redfern and Kempsey in NSW; Fitzroy, Shepparton and Gippsland in Victoria; Brisbane and Townsville in Queensland; Adelaide, Port Augusta and the Pitjantjatjara Homelands in South Australia; Perth in Western Australia. In the Northern Territory: Alice Springs (Congress), Lyappa Congress in Papunya; Urapuntja in Utopia.

championed by many of the States and the Northern Territory. The Federal government was continually lobbied by Aboriginal health activists who had formed a national confederation of Aboriginal health service organisations, the National Aboriginal and Islander Health Organisation (NAIHO) in 1975. 'NAIHO', wrote Gary Foley, its then secretary, 'is an overtly political organisation'. He continued, (Foley 1982, p.15)

*... for the simple reason that we believe the ultimate solution for the disastrous state of Aboriginal health can only be resolved in a situation whereby Aboriginal people have: a) total control of their own affairs; b) control of resources and facilities to enable them to alleviate ALL contributing factors to their problems; c) inalienable Title to Land which can be an economic base.*

In the 1990s there are over 50 community-controlled services providing comprehensive primary health care. They have now become accepted as part of the range of services available to indigenous people - although even now the more conservative State or Territory governments still assert that they merely 'duplicate' other available services.<sup>5</sup> Quite simply, they are intended to be primary health centres where Aborigines feel comfortable, where they can be greeted by an Aboriginal receptionist, see an Aboriginal health worker, and 'be treated with respect by people who know something of their lives and culture' (Anderson 1994b, p.37). Nevertheless, it must be said that not all Aboriginal people in an area with access to an AMS automatically make use of it. It is known that political and family disputes, confidentiality fears, and transport difficulties inhibit usage in some cases; some people simply prefer to attend general practitioners known to them.<sup>6</sup>

In the years before the present relatively secure status enjoyed by AMSs however, Aboriginal health activists were forced to lobby constantly in defence of their position. As a result of frustration at the reluctance of State and Federal governments to fully endorse their role, and because of the constant threat of funding cuts, Aboriginal health

---

<sup>5</sup> The Northern Territory Health Minister Dennis Burke expressed this view in July 1997 (Pers.comm. 1 July 1997). Saggers and Gray admit that AMSs do duplicate services to some extent, but argue that this is necessary as they provide services for those who would otherwise be unwilling to use mainstream services (Saggers and Gray 1991).

services spokespeople (like their counterparts in the land rights movement) turned to the international arena, primarily the United Nations and WHO, for validation of their position. To this end, NAIHO and the AMSs marshalled the principles of community participation in primary health care and in health planning that were promulgated in 1978 by WHO as a result of the Alma-Ata Declaration<sup>7</sup>. By embracing these principles of community-controlled primary health care Aboriginal organisations were able to lobby for ideals of social justice, while simultaneously countering suggestions that separate services were a luxury that the government could not afford. Jack Waterford (1982, p.16) explained why there was this recourse to the international arena:

*Although the Aboriginal genius in [the community controlled AMS] development has been marked ... there has been sound reason for pointing instead to the Services' links with third-world health experience, third-world health ideology, and in particular with the emphases so strongly put by the World Health Organisation. These links are there and should not be ignored. But why they, rather than the unique Aboriginal contribution, have been so emphasised is simply because of the need Aborigines have had to demonstrate that their idea was not so dangerously radical as to be dismissed - that in fact it was general Australian ideology which was out of touch.*

The Aboriginal health lobbyists made use of WHO and Alma-Ata in two ways. First as Waterford has argued, the principles of community involvement in health care as enacted in the AMSs could be supported and legitimised by reference to a recognised international body. Second, Alma-Ata provided reaffirmation of the broad WHO definition of health. This opened the way for the creation of further elaborated health

---

<sup>6</sup> For example, a study of health needs in the Townsville region found that 80percent of Aboriginal and Islander residents used the AMS, while the rest attended general practices, 24 hour clinics or the hospital (Speare and Kelly 1991).

<sup>7</sup> Aboriginal representatives of the Victorian Aboriginal Health Services visited WHO in Geneva in 1979 to 'try to get the WHO to publicly condemn the Australian Govt in regard to the outrageously disastrous state of Aboriginal health ... They were expecting a sympathetic ear from the WHO, which after all, has considerable influence in determining acceptable minimum standards of health for all countries to work towards. But, alas, that was not to be! They were instead told that the WHO would not even consider any criticism of the Australian Government for the simple reason the WHO was unwilling to risk losing the affiliation fees of the Australian Government' (AMS Newsletter Oct-Dec 1979:3). Indigenous and third-world groups from Canada, North and South America and Africa visited AMSs in 1980 because they

definitions, indeed of an 'Aboriginal' definition of health, which in turn became valuable ammunition in the defence of AMSs as being exceptional services which provided for Aboriginal cultural difference. While the independent health services initially evolved because of the desperate need for accessible and sympathetic health care, their continued existence and expansion required constant lobbying and persuasion of governments. Assertions of difference and of culturally specific perceptions of health became part of the battery of argument used in this ongoing ideological struggle with the government.

### 3. The Alma-Ata Declaration

At the major international conference on primary health care, jointly sponsored by WHO and UNICEF at Alma-Ata in the Soviet Union in September 1978, several influential and socially-progressive principles were announced which have had far-reaching consequences throughout the world. These formed a significant break from WHO's earlier reliance on the 'top-down' transfer of professional medical authority to solve the world's health problems. Most important of these new principles was a definition of primary health care which radically linked improvements in population health with broad social progress (National Centre for Epidemiology and Population Health 1992).

The definition of primary health care in the Declaration of Alma-Ata was specific:

*Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination... It is the first level of contact with individuals, the family and community with the national health system, bringing health care as close as*

---

'recognise the worth and effectiveness of community health programs developed by Aborigines themselves' ('Reflections on 1980' AMS Newsletter Nov-Dec 1980).

*possible to where people live and work, and constitutes the first element of a continuing health care process.*

Primary Health Care (PHC) was to be the prime means of achieving the ambitious goal of 'Health for All by the Year 2000', announced by WHO in 1975, and versions of PHC have been taken up by virtually all developing nations.<sup>8</sup> In 1997 WHO published a report which revisited Alma-Ata and assessed the progress of primary health care (Tarimo and Webster 1997). Australia endorsed 'Health for All' as Federal policy in 1979 although it was slow to follow up on this commitment. In fact, it was in the area of Aboriginal health that PHC principles have been most energetically acted upon (National Centre for Epidemiology and Population Health 1992). The socially progressive ideals of Health For All were made explicit in the use of some key phrases of the Declaration of Alma-Ata: that health is a 'fundamental human right'; that people have the right (and duty) to 'participate individually and collectively' in their health care; and that primary health care is associated with the 'spirit of self-reliance and self determination'. Politically, the Declaration links primary health care to ideals of equity, participation and sustainability, and in Australia these principles were and are linked by Aboriginal people to their right to self determination and community control.

The radical nature of the assertion by WHO that people had a right to participate in the planning and implementation of their health care was no accident. As Sung Lee persuasively argues, the very fact that Alma-Ata took place at all, and that the Declaration was so politically radical, was because of the huge impact of China on WHO (Lee 1997). Lee suggests that there had been growing discontent in the developing world about the paternalistic assumptions that underlay the role of WHO; the assumptions that it was waging war on disease using Western medical science and that ultimately the ex-

---

<sup>8</sup> Since then there has been ongoing debate about the nature and scope of primary health care, with a split between those advocating Comprehensive Primary Health Care (which includes many activities that do not in themselves affect mortality), and proponents of Selective Primary Health Care. The latter became known for its six basic measures (GOBI-FF)(growth monitoring, oral rehydration, breast feeding, immunization, family planning and female education). UNICEF adopted the reductionist approach, which was far from the original conceptualisation of PHC as a solution to the social, political and economic roots of disease (Bloom 1987) (Mull 1990).

colonial peoples would abandon their superstitious beliefs. A healthy world would be achieved by the production of more and more physicians. The developing nations could not get enough doctors though, and by the early 1970s their discontent led to a commissioned study on methods of promoting *basic* health services. China gained membership of WHO in 1973. By this time, China had trained approximately a million 'barefoot doctors' - peasants, factory workers or housewives who had three to six months of training in traditional Chinese and Western medical techniques. They were not medical professionals but delivered basic preventive and curative health care.<sup>9</sup> The success of the barefoot doctors scheme was stressed by China - and WHO was suitably impressed. So between 1973 and 1978, with the support of the Soviet Union and statements from African states (some of whom had been recipients of Chinese aid and who began to see the need for health policies aimed at the masses), the Chinese succeeded in giving WHO a new ideology. It was the Soviet Union that called for an international conference on primary health care (a proposal that did not go uncontested) and was ultimately successful in its offer to sponsor the conference at Alma-Ata. As Lee (1997, p.43) concludes,

*By the 1970s WHO had abandoned the war on disease, and through the challenge of the socialist giants it discarded its assumptions of the natural beneficence of Western professional medicine in favour of a more politicised rhetoric of health.*

#### 4. The WHO definition of health

The Alma-Ata conference in 1978 also reaffirmed what has come to be known as the WHO definition of health, which had already been aired at the first World Health Assembly thirty years before, in 1948. At the first World Health Assembly, the President, Andreas Stampar made a presentation which addressed this now-famous preamble to the Constitution of the WHO. In 1948 Stampar (Stampar 1966, p.200) explained that:

---

<sup>9</sup> According to Velimrovic (1990) it was commonly believed that the 'barefoot doctors' were traditional healers in another form. However, he points out that 80 percent of the items in their medical bags were Western medical products.

*Disease is not brought about only by physical and biological factors. Economic and social factors play an increasingly important part in sanitary matters which must be tackled not only from the technical, but also from the sociological point of view ... Since health for everyone is a fundamental human right, the community should be obliged to afford all its peoples health protection as complete as possible.*

The preamble defines health as ‘complete physical, mental and social well-being, and not merely the absence of disease or infirmity’ and this definition of health has been taken up by governments<sup>10</sup> and - perhaps even more enthusiastically - by indigenous groups in the struggle for equitable health care. The Aboriginal health discourse gives the broad WHO definition considerable currency, and one of the reasons for this is its coexistence with the model of primary health care. At the heart of the WHO definition is the relationship between health care and wider social practice: the broader enterprise of social development which links improvements in population health with broad social progress, and with self determination (National Centre for Epidemiology and Population Health 1992). The WHO definition of health has also achieved unprecedented prominence in Aboriginal health activist discourse because it is said by these spokespeople to be akin to their own ‘holistic’ conceptualisations of health. These are positioned as being radically different from the reductionist ideas that are normally the defining characteristic of the Western medical tradition. One of the supporting pieces of evidence for the holistic nature of Aboriginal conceptions of health, and an additional argument utilised in the promotion of Aboriginal cultural exceptionalism, is that Aboriginal languages are said to have no single ‘word for health’.

#### **4.1. Critiques of the WHO definition**

It is important at the outset to acknowledge that the WHO definition of positive health is itself contested. It describes an *ideal*, a potential state. Rene Dubos, who was a keen

---

<sup>10</sup> Referring to the original 1948 Preamble definition (and writing in 1973, before the reaffirmation at Alma Ata), Moodie cited the disparaging comment that the definition had become something of a public relations slogan (Moodie 1973).

supporter of the ecological or holistic model of health, also argued that the notion that humankind can attain perfect health and happiness is an illusion manifested in many different forms throughout history - he wrote a book entitled *The Mirage of Health* (Dubos 1959). In several publications, he refers to complete well-being as a utopian ideal (Dubos 1969; Dubos 1970) and sees it more realistically, as a

*modus vivendi enabling imperfect men to achieve a rewarding and not too painful existence while they cope with an imperfect world. In this light, health cannot be defined in the absolute, because different persons expect such different things from life (Dubos 1970, p.97).*

Notwithstanding the eager utilisation of the WHO definition in some quarters, many other commentators have been less than enthusiastic about it, suggesting that the WHO definition is all-inclusive and ponderous, that it has no clearly defined edges, uses words which have no self-evident meanings, and is unworkable as a basis for measurement of health (Kue Young 1988; Moodie 1973). In his 1973 book *Aboriginal Health*, Peter Moodie commented that such an open-ended definition 'makes it impossible to rate an individual's total health at a point in time, or to compare individuals' (Moodie 1973, p.6). Gilbert Lewis, working in Papua New Guinea, agreed that 'health' was an ideal, but observed that in practice an individual doctor has no reliable positive indications of when such an ideal balance has been achieved, and notes that the borderline between health and illness depends on the patient, who decides 'I am ill.' (Lewis 1986). John and Pat Caldwell, two of Australia's leading health transition researchers, refer to it as 'unusable and almost Utopian' (Caldwell and Caldwell 1995, p.255). They suggest that uncertainty about what health really means has held back health transition research.

Perhaps the most serious of these concerns is the utility of such a broad definition at the level of policy and practice. While governments can subscribe in theory to the rhetoric of the broad definition, when policies are studied in detail, the concept of health being used is often the narrow epidemiological one (Smith 1997). As Johannson observes,

*All of the definitions of ‘health’ and associated measurement strategies can make good sense in some context. Vague concepts like ‘health’ are vague because they stand for a set of related but distinct phenomena. Real world complexity makes the existence of an umbrella concept convenient for abstract purposes, but meaningless for most practical, policy-related purposes. When action is required, agreement on meaning is required, and what particular meaning is ‘true’ depends on what particular problems are being faced at a particular time in a particular context. (Johannson, 1995, p.376).*

These critiques reinforce an ongoing tension between definitions of health which describe it as an ‘absence of disease’ and the broader formulations of ‘wellness’ which are embodied in the WHO definition. This tension was identified as being a recurring theme by the authors of a National Centre for Epidemiology and Population Health report on the role of primary health care. The authors suggest that rather than seeking to resolve the perennial debate over which is the ‘correct’ position (ie absence of disease, or wellness), we should deconstruct the significance of the debate itself (National Centre for Epidemiology and Population Health 1992). Below, I propose an analysis of the meaning of this discourse as it is lived out in the Aboriginal health context.

#### **4.2. The elaboration of the WHO definition**

It was in *the context of the struggle* to reinforce the unique role of separate Aboriginal-run services and of Aboriginal health workers, that the contested definitions of health have come to prominence in Australia. In order to justify their presence and highlight the continued need for special services for Aborigines which are respectful of cultural differences, Aboriginal people *emphasise* these differences, asserting that their conceptualisations of health are different from (and superior to) what is frequently designated as the ‘Western bio-medical model’. They have harnessed the broad WHO definition to assist in this task.

*The Aboriginal approach to prophylaxis and curing is a holistic one. It recognises the physical, personal and spiritual dimension of life and health. In many ways, the Aboriginal perspective on health and illness is closer than that of Western medicine to the WHO's definition of health as 'a state of complete physical, mental and social well-being, not merely the absence of disease' (Reid 1982, p.42).*

Aboriginal health service spokespeople frequently stress that Aboriginal definitions of health are synonymous with that of WHO and assert that these are in stark contrast with the 'medical model'. They have enlarged upon the three WHO ingredients of physical, mental and social. They have argued that elaboration has been necessary in part because the word 'health' is understood differently by Aboriginal people, and that indeed indigenous languages in Australia have no similar word. The most influential document in this regard is the report of the working party on the National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party 1989). Notwithstanding the noted scepticism about making policies based on umbrella concepts actually work, in this report - widely held to be the blueprint for Aboriginal health in the 1990s - health is defined as physical as well as social, emotional and cultural well-being:

*'Health' to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity. (National Aboriginal Health Strategy Working Party 1989, p.ix).*

The Working Party therefore sees health as:

*Not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a 'whole of life' view and it also includes the cyclical concept of life-death-life.*

*In Aboriginal society there was no word, term or expression for 'health' as it is understood in Western society ... The word as it is used in Western society almost defies translation but the nearest translation in an Aboriginal context would probably be a term such as 'life is health is life'.*

The exegesis provided by the NAHS report has become canonised and has been faithfully - and unquestioningly - reiterated in a flood of subsequent documents including Aboriginal submissions, government reports, the Royal Commission into Aboriginal Deaths in Custody, masters and doctoral dissertations, and medical journal editorials. It became the 'mission statement' for the health branch of ATSIC and has been incorporated into several State/Territory health policy documents (Aboriginal and Torres Strait Islander Commission (ATSIC) 1994b; Beaton 1994; Burden 1994; Territory Health Services 1996). The incorporation of this Aboriginal invention by aspects of the state apparatus (for example its incorporation into official policy documents) is an example of what Peterson has termed the 'unwitting reproduction' of indigenous social order (Peterson 1999).

#### **4.3. The construction of polarised positions**

Following the NAHS report which added 'cultural' to the original three-pronged WHO definition, there have been further elaborations on what constitutes the 'Aboriginal definition' of health. For example, a combined Aboriginal health services forum in South Australia defined health as 'a state of complete physical, psychological, social, spiritual, emotional and cultural well-being for the individual and his community'. An Adelaide Aboriginal man told this committee that for him health was 'feeling powerful about my Aboriginality' (Kirke et al. 1993, p.101). Their report continues:

*Pukulpa (a Pitjantjatjara word) translates more readily to 'happiness' and implies a state of well-being not dissimilar to that described by the WHO definition of health.*

A textbook for students of Aboriginal studies contains this paragraph on the holistic approach to health:

*Aboriginal conceptions of health are radically different from (the) bio-medical perspective ... It is imperative that medical authorities take cognisance of the Aboriginal perspective with regard to health and well-being and accept that in contrast to the more focused clinical and disease-oriented approach of non-Aboriginal health professionals, Aboriginal peoples' collective concerns are to regain their land, to ensure that their children have tucker and to be able to undertake social obligations including ceremonial duties (Burden 1994, pp. 169,172).*

In New Zealand a similar process of elaboration has taken place. Maori physicians have provided a number of consciously refined definitions as a result of workshops convened explicitly to produce them. In 1982 a definition of health was proposed to be the four-way interaction ('the four-sided house' Whare Tapa Wha) of spiritual, mental, and physical aspects, and the extended family and community. Another model was presented in 1984, based on the octopus, with eight tentacles (representing spirituality, mental, physical, extended family, emotional, life principle, unique identity and inherited strengths) (Durie 1994; Pomare et al. 1995). While since then these definitions have become formalised as the 'traditional Maori approach to health', Mason Durie the Maori psychiatrist who was largely responsible for creating them, states that it is more correct to think of them as according with *contemporary* Maori thinking. This is an important acknowledgement, as these notions had not been explicated in this way before the early 1980s (van Meijl 1993). In effect, the Maori definition of health is an invented tradition in the sense elucidated by Hobsbawm (Hobsbawm 1996), that is, as an attempt to establish continuity with a suitable historic past.

Critics of the Maori definitions say that they are based on a romanticisation of the past, are devoid of practical application and risk discouraging Maoris from seeking appropriate medical care. They say that such definitions produce a sense of futility among health

workers - how, for example can a diabetic regain health if his or her land injustices continue to be ignored? However, in defence of these wide-ranging definitions Mason Durie observed that they were a reminder to the world that there was more to health than biological dysfunction (Durie 1994).

Both Maori and Aboriginal definitions are continually positioned in the discourse on health as being antithetical to the bio-medical, technological, one-dimensional, model of Western medicine. Nathan and Japanangka in their book *Health Business* (1983), which was commissioned by an AMS, articulate what they see as being diametrically opposed approaches to health:

*The approach of one is mainly particularistic, bio-physical and mechanistic, and in it the disease-orientation is paramount. The other is holistic, emphasising the life of a person in a way which links ill health with health ... Western medicine focuses on the disease symptoms of the individual, in contrast to indigenous medicine, which organises cultural experiences and social cohesion around the sickness of community members ... the proponents of Western medicine ... equate reality with material reality, ... treat the body as a machine, ... see medicine as a set of skills and techniques to be marketed, and to regard health as something to be fetishised and sold as a commodity (Nathan and Japanangka 1983, p.91).<sup>11</sup>*

## 5. The ongoing influence of WHO principles

Three key principles of the Alma-Ata Declaration have had an on-going influence on Aboriginal health - not just in theory, but also in practice. These are: the promulgation of the broad definition of health, the emphasis on community participation, and the role of primary health care. As suggested above, the existence of the WHO definition of health was instrumental in prompting subsequent Aboriginal definitions of health. The role of

---

<sup>11</sup> Further analyses of the tension between models of health include Lupton, Illich and Foucault (Lupton 1994) (Illich 1975) (Gordon 1980). Lupton provides a critique of the bio-medical model arguing that Western medicine is directed towards controlling the body and keeping it from descending into the chaos and disorder of illness.

community participation in primary health care came to form supporting arguments that Aboriginal people should indeed run their own health services, and also it provided legitimisation for the role of Aboriginal people as community health workers. As we have seen, the idea that ordinary people could be trained as para-professionals in order to work among their own communities, was influenced by China's 'barefoot doctor' program.<sup>12</sup> In Australia, these three interrelated issues have in turn been informed by the crystallisation of a self-conscious indigenous identity, and an intentional cultural separation from mainstream Australia.

The emphasis on 'well-being' (rather than freedom from disease), the ideal of community participation, and the existence of indigenous para-professionals in the form of Aboriginal health workers, all served - in theory - to downplay the position of the fully-fledged medical practitioner. This was despite the fact that doctors had played a key role in the establishment of the AMSs in Redfern and Fitzroy by providing a professional legitimisation to the embryonic services which was necessary for their credibility in the eyes of funding agencies.<sup>13</sup> Nevertheless, the ideology of AMSs stressed that doctors were unimportant, even that they were the *least* important people in the services: 'Aboriginal Medical Services are not run by doctors or other medically qualified people' (Foley 1982, p.15).<sup>14</sup> In Melbourne, the 'white professional staff' are used as 'sources of advice and expertise and the Aboriginal staff and local residents are the decision-makers' (Nathan 1980, p.90).

Apart from its influence behind the scenes at the WHO between 1973 and 1978, the 'barefoot doctors' program in China also came to prominence in the Aboriginal context

---

<sup>12</sup> Nevertheless, the plan for the training of barefoot doctors in China was that as their standards of performance improved, they would become paramedical workers, increasingly like modern medical practitioners (Velimrovic 1990).

<sup>13</sup> Indeed, it was the concerns of a female doctor over the lack of medical treatment of Lake Tyers Aborigines which initially provoked moves for an Aboriginal health service in Victoria (Nathan 1980).

<sup>14</sup> This antipathy towards doctors reflects the Maoist position of the 1960s: that doctors were 'bourgeois intellectual aristocrats'. Mao's 26th June Directive (1965) was a withering attack on the elitism of the profession in which he suggested changing the name of the Ministry of Public Health to the 'Ministry of Urban Health, the Ministry of Gentlemen's Health, or even the Ministry of Urban Gentlemen's health' (Lee 1997:34). Even today in Aboriginal health services, the power of doctors is circumscribed in a number of ways. One health service deliberately employs a number of doctors on a short, sessional basis, rather than having a smaller number of full-time practitioners, in an effort to ensure that their influence is curtailed.

in the 1970s. Joan Winch, an Aboriginal nurse, suggested that such a scheme could be a working proposition in Aboriginal communities, because it was a grass-roots program flexible enough to deal with the variety of what she called 'tribal areas', each with particular rules and idiosyncracies (Winch 1978, p.9). She saw it as an alternative to the 'blanket' system which she thought was incapable of taking the needs of people in specific localities into consideration. An Aboriginal health delegation to China in 1981 (which included the Chairman of NAIHO, Bruce McGuiness), produced expressions of hope that there would be future exchange programs between Aboriginal health workers and Chinese barefoot doctors (Dodd 1981). At the AMS in Melbourne, the barefoot doctor scheme influenced thinking about the training of Aboriginal health workers:

*The VAHS has been influenced by the Chinese health care system ... In China, health is a community and social concern. More importantly, it is a political matter and their health system was changed by people who were given the opportunity to take responsibility for it; motivated by the slogan 'Serve the People'. The intention of the VAHS is to equip indigenous workers of a 'barefoot doctor' variety with the knowledge and ingredients of bush medicine, together with rudimentary diagnostic and treatment skills of Western medicine. The Chinese have combined successfully the traditional and Western medicines and procedures (Nathan 1980, p.96).*

The service planned to use an adapted version of the Barefoot Doctor's Manual as the basis for training.<sup>15</sup> It is clear that 'barefoot medicine' had great appeal to the Aboriginal health movement because of its political agenda, which was explicitly designed to break the power of the medical professionals and to give the people a part in their own health care. Rifkin observes that the whole scheme in China was a political, rather than a technical creation (Rifkin 1978).

The changing climate at WHO and the growing interest from developing countries in the barefoot doctors not only had an influence on the Aboriginal community-controlled health movement. It also had an impact on *government-run* Aboriginal health programs.<sup>16</sup>

<sup>15</sup> In 1982 the VAHS trained its first 20 Aboriginal health workers (Thomson 1984).

<sup>16</sup> It appears that the development towards the 'barefoot doctor' model in the radical Aboriginal health services in the south-east took place independently of the government-instigated processes in the Northern

In the 1970s these philosophies began to have an influence on policy and practice in the Northern Territory, traditionally a bastion of conservatism. Its Aboriginal policy, for example, was not self determination, but the less radical self management, as espoused by the Federal Liberal Coalition of 1975-1983. Self management stressed accountability, responsibility and Aboriginal control at the service delivery level rather than at the level of policy-making and priority-setting. The Territory launched into a series of attempts to make Aboriginal people more responsible for their own health, and in so doing they made use of selected principles from the WHO.

In 1971 the Territory Health Department had employed two Aboriginal traditional healers (known as *ngangkari* across some regions of Central Australia), as 'liaison officers' at the Papunya Health Centre, and more were employed in communities such as Warrabri. Health staff tried to train the *ngangkari* in modern concepts of medicine, but it soon became clear that institutionalising the role of the traditional healer was not going to work and that any trained Aboriginal medical assistants had to be a separate group of people (Devanesen and Briscoe 1980; Elkin 1977; Fleming and Devanesen 1985). Australia's own 'barefoot doctors' were about to be born in the form of Aboriginal health workers.

### **5.1. The Northern Territory Aboriginal Health Worker Program**

In 1974, the Federal Minister for Health,<sup>17</sup> Dr D.M. Everingham, invited 'a WHO expert' Dr John Hirschman, to the Territory to make recommendations on health worker training which he did, proposing that the Aboriginal community concerned should be involved in their selection. In 1975, Gordon Briscoe, then a senior Aboriginal officer of the Commonwealth Department of Health, proposed the establishment of a training centre for Aboriginal health workers, an 'Institute for Aboriginal Health Studies' in Central Australia. In 1976 there was an in-service training for 'hospital assistants' at Warrabri; and in 1977 the first official training course for 150 Aboriginal Health Workers (AHW) took place in Alice Springs (Devanesen and Briscoe 1980; Thomson 1984).

---

Territory, although one Aboriginal activist, Gordon Briscoe, was involved in the development of Redfern and in the proposed Alice Springs health worker training centre.

<sup>17</sup> At this time, Northern Territory health was still administered by the Commonwealth Government. The transfer to the Northern Territory administration took place in January 1979.

The Territory saw the AHW program as a radical step towards the ideal of Aboriginal community involvement in its own health. A Northern Territory Education and Training Task Force reported that every Aboriginal community had the right to nominate individuals to train as AHWs and that,

*Every Aboriginal and non-Aboriginal health worker involved with Aboriginal health care has an obligation to train AHWs, which will encourage further participation in health services by Aboriginal people and promote community development (Northern Territory Division 1977, p.11).*

This Aboriginal Health Worker plan was influenced by a medical practitioner from the Indian sub-continent, Dr Dayalan Devanesen, who had come to Australia in 1974 from a community health development background. Devanesen was influenced by 'bottom up' rather than 'top down' principles of health development, and by writers on the politics of health care such as Susan Rifkin and Maurice King<sup>18</sup> - all of which was given official endorsement by WHO in 1978. Devanesen, who worked as a District Medical Officer in Central Australia, also encouraged the use of Aboriginal art as a means of making health care meaningful.

The AHW program aimed to train 300 workers by 1979; in fact 260 were trained by 1982 (Northern Territory Department of Health 1982). However, a series of difficulties and tensions arose in the program. These were related to what can now be seen - with hindsight - to be a potential dissonance within the WHO principles of primary health care: that is the assertion that health care should be both 'socially acceptable' and

---

<sup>18</sup> Devanesen presented the Lambie-Dew Oration in 1980 to the Sydney University Medical Society in which he began by likening the health worker training program to the barefoot doctors scheme in China and village health workers in Africa and Guatemala. He cited Susan Rifkin saying that political solutions were needed for poor health and that health care workers need to mobilize their communities to improve their own health (Devanesen 1980). Maurice King is the author of seminal works on primary health care, notably *Medical Care in Developing Countries* (King 1966). Devanesen observed that in India 'we all ran around with Maurice King under our arms'. He adapted King's schema of health resources and people, which in developing countries shows few resources at the top of a pyramid above a large mass of people. Devanesen's adaptation reversed this to fit with the situation in 'fourth-world' Australia, with the pyramid inverted so that many resources exist above a small number of people (interview with Dayalan Devanesen 8 July 1996, Darwin).

'scientifically sound'. One of the key issues on which the Northern Territory program faltered was the literacy of the health workers. With the communities selecting their own health workers using their own criteria of suitability, and with an existing low Aboriginal literacy rate, many of the health workers could not read or write. In terms of the WHO criteria for primary health care, the individuals were 'socially acceptable' but their lack of literacy and numeracy meant that their medical or 'scientific' capabilities were limited.

The tensions between community participation and professional expertise epitomised by the literacy issue, as well as the differing expectations associated with self determination and self management, were analysed by Eileen Willis, the person hired to try and overcome the literacy problem (Willis 1984; Willis 1985). The Territory AHW policy meant that health workers could undertake training and obtain employment without having to be literate. In this respect, as she points out, what happened in Australia differed from virtually every other developing country which had implemented the community based health worker idea. In these countries, health workers were selected from their communities by their communities - but out of a pool of literate individuals. In the Northern Territory it was intended that the registered nurses would train their AHWs in literacy *on the job* (having had training themselves) with the support of a medical literacy teacher. Once this was accomplished, the aim of the NT Health Department was then to hand over management and treatment of all first level health care to AHWs. Willis found that little literacy (or primary health care) teaching occurred: the AHWs seemed uninterested in learning literacy, and the nurses found it nearly impossible to teach it, as they had no instruction in how to teach literacy. Literacy teaching was marginal to the interests of both groups, although several nurses worked hard to provide the training they were expected to give (Willis 1997). No-one with any professional expertise in literacy or teaching English as a second language would have expected this plan to work. There were also uncertainties about the expected roles of AHWs - the notion of the AHW as 'cultural broker' suggested the role of go-between, or helper (Soong 1981). On the other hand, the 1981/2 Territory health policy announced that nurses would be withdrawn from front-line work in Aboriginal communities, leaving the AHWs in charge. When in 1981 the nursing staff were withdrawn without warning at

Belyuen near Darwin, the community reacted with dismay (Coombs, Brandl, and Snowdon 1983, p.299).

Willis found that many Aboriginal communities found the idea of operating without a trained non-Aboriginal nurse on the premises threatening, and the health workers utilised tactics of resistance. The health workers were frightened of being left in charge and realised that many community members still did not trust their skills<sup>19</sup>. Willis's analysis of the failure of the literacy program showed that the AHW resistance to literacy was because they realised that the more educated they became, the more likely it was that their nurse would be withdrawn (Willis 1997). It is clear even fifteen years later that literacy is still a vexed issue. A study published in 1995 found that 63 percent of health workers interviewed in Central Australia did not believe that literacy was necessary. The report is itself equivocal about the necessity for literacy, suggesting that the requirement for literacy is evidence of 'Western attitudes' which act against traditional health practices, while at the same time acknowledging that health workers are the least prepared educationally, least listened to and least respected of all the health professionals (Tregenza and Abbott 1995). This less than enthusiastic attitude towards the need for full literacy for Aboriginal health workers has been critiqued by Tsey who observed tersely that 'to be illiterate in contemporary Australian society is to be powerless' (Tsey 1996).

It is probably true to say that the ambitious AHW program which had graduated its first 150 trainees in 1977, by the early 1980s had not produced the results the Territory government had in mind. Despite (or perhaps because of) this program, Aboriginal people in the communities persisted in the belief that the 'health problems' which everyone kept talking about were the responsibility of the health people, rather than themselves. The clinics on settlements were perceived to be where health 'happened', rather than it being anything to do with how people lived their daily lives, and thus

---

<sup>19</sup> In contrast, in New Zealand it was the public health nurses who did not trust the skills of Maori community health workers, as described in a case study by Wood (Wood 1990). An Aboriginal man from Alice Springs, Tony McMasters, describes some of the difficulties of being an AHW including the expectation that they are 'agents of change' but often have fragmentary or no knowledge, and that their professional advice is sometimes interpreted by Aboriginal patients to be interference or personal criticism (McMasters 1996).

government was seen to be largely responsible for it. In short, Aboriginal community members did not take up with enthusiasm the notion that they were responsible for their own health. They still relied on indigenous traditional practitioners, and increasingly on clinics and fully trained nursing sisters. As Willis's work shows, the health workers themselves were reliant on the nursing staff, and resisted attempts to become literate and more independent, in order to ensure that the nursing staff stayed. The Territory government realised that a new direction was needed, and the procedures they put in place to bring this about were responsible for giving birth to the 'Aboriginal' definition of health.

## 6. The construction of an Aboriginal definition of health: 1981

The broad, socially-cognisant notions of what health can mean - and the idea that these notions are more appropriate when considering Aboriginal health - were obviously in the air in the early 1970s, before the Alma-Ata declaration of 1978. As early as 1973, DAA's journal *Aboriginal News* reported on a 'Health and Community Development Workshop' held in Alice Springs at which,

*The participants decided that a broad definition of health was far more useful for the purposes of the Workshop than merely one which indicated the absence of organic disease. The point was raised that an Aboriginal's concept of health also includes having satisfying personal and spiritual relationships, children, and a minimum of violent conflict.<sup>20</sup>*

These ideas had not been formally 'ratified' domestically, as it were, even if they were shortly to be ratified internationally. I have already mentioned that the Maori definitions of health were arrived at through active processes of debate and construction. Experts were gathered together to produce phrases which could be used to guide policy, stimulate health advancement and have political influence. It turns out that this is what happened in the case of the 'Aboriginal definition of health' as well.

## **6.1. A government-sponsored invention**

In Darwin, in September 1981, Dr Keith Fleming called five people together to make a Territory policy on Aboriginal health. Fleming was a dynamic health administrator who was the new Secretary for Health in the Northern Territory. They met to discuss issues identified as being important for the development of the next stage of the Northern Territory's approach to providing health care services to its Aboriginal population. Only a month before, a Division of Aboriginal Health had been established within the Territory's health department, with the aim of providing a focus for the impetus required to improve Aboriginal health. The meeting in September 1981 was made up of two Aboriginal people, Margaret Valadian and Gatjil Djerrkura; Dr Dayalan Devanesen; Dr John Hargrave and Dr Keith Fleming. These individuals came from a variety of backgrounds: Margaret Valadian (MBE) was born in Darwin, trained in social welfare and education, and established the Aboriginal Training and Cultural Institute in Sydney in 1978. Gatjil Djerrkura was an Aboriginal man in his 30s, born at Yirrkala in East Arnhemland, educated at the Methodist Training College in Brisbane, and was at the time the Chief Minister's senior advisor on Aboriginal affairs.<sup>21</sup> Dr Hargrave had established a reputation in the care of leprosy patients and was the newly-appointed head of the Division of Aboriginal Health. As mentioned earlier, Devanesen had come from teaching in a community health department in India, and coined the phrase 'two-way medicine' to incorporate the best of indigenous and Western concepts.

The issues to be discussed included how Aboriginal people perceived 'health', and what was to be the Territory government's policy. Two of the participants later presented a paper in which the proceedings of this meeting were described:

---

<sup>20</sup> *Aboriginal News* 1973, 1(2):16

<sup>21</sup> In December 1996, Gatjil Djerrkura was appointed as the Chairman of the Aboriginal and Torres Strait Islander Commission. On appointment, the Minister for Aboriginal Affairs praised him as a 'role model for his people', bringing to ATSIC a 'vast amount of experience in indigenous administration and private enterprise, as well as someone equally comfortable in both indigenous and non-indigenous cultures' (*ATSIC News*, summer 1997).

*A major breakthrough occurred after many hours when Gatjil developed a form of words which explained what 'health' meant to Aboriginal people. The discovery was a moving experience. By way of explanation, all societies develop a single word to describe indescribable concepts - for example, leadership, love, honour, courage. Gatjil told us there is no word 'health' in Aboriginal languages. He said that health means 'to promote and strengthen the life of Aboriginal people as a means of ensuring their survival and growth'. We then found that this sentence can be translated back as a single word into every language we tested. For the Warlpiri people of Central Australia this word is 'wankaru' - so we could now say instead of the 'Yuendumu Health Centre' - the Yuendumu Wankaru Centre (Fleming and Devanesen 1985)*

The phrase 'health is life' thus became the slogan on which the Territory based its focus on Aboriginal health at the time. The Territory sponsored a Health is Life movement which included events such as a week of activities at Yirrkala (Gatjil Djerrkura's home community) with dances and songs for health. The slogan and the orientation it was intended to promote provided a way out - at least on paper - of the dilemma articulated by concerned health professionals which was that Aboriginal communities had been slow to enter into full involvement in their own health improvement. The notion that health apparently meant 'life' - all aspects of life including food, housing, family - placed the issue more firmly in the realm of communities, and, it was hoped, in the hands of the people themselves.

*Thus the important question of responsibility could be properly addressed. 'Health' is a Western concept - and therefore the Government's responsibility. When the Department said to an Aboriginal community that it had a 'health problem' the community rightly said 'well, you fix it'. With the knowledge of the meaning of health to Aboriginal people, the Department now had an effective means of communication regarding 'health' in both cultures and could clearly define responsibilities (Fleming and Devanesen 1985).*

The NT Department of Health's Annual Report that year made explicit the objectives and principles encapsulated by the Health is Life definition. The first objective was: 'to promote amongst Aboriginal people an awareness for the need for and active commitment to health and fitness as a means of survival and growth'. The principles included the following:

*In keeping with the Government's policy of self management, Aboriginal people themselves also have a responsibility to promote their own health LIFE. The most effective programmes are those developed through a process of community involvement and participation. The most effective health care service is one which employs Aboriginal people at all levels of the service (Northern Territory Department of Health 1982).*

Although these principles at face value express some of the basic ideals contained within the Alma-Ata declaration, the repeated stress by the Territory government on responsibility does imply - however covertly - that it the responsibility of Aboriginal people themselves, rather than the Territory government's health clinics, to get on with the business of improving health. It is certainly remarkable that the interpretations placed on Djerrkura's translation of 'health' fitted so neatly with the Department's pre-existing efforts to emphasise the Aboriginal role in maintaining health in everyday life - food, water and shelter: health as life.

As a result of the Territory government's promotion of 'health is life', the two assertions that there was 'no word for health' and that health was perceived differently by Aborigines were widely disseminated, and began to be taken up by others.<sup>22</sup> At around the same time as the 1981 meeting which began this process, another Territory medical

---

<sup>22</sup> This has not prevented later commentators from claiming it for themselves. Ten years after this, the Healthy Aboriginal Life Team in Central Australia pointed out that the English word 'health' had become associated with specialised outsiders, that it really meant a 'process of living'. They presented Aboriginal designs and paintings for health, a process that had commenced in the 1970s. In 1994 Hazlehurst described this as a 'new idea for health' (Hazlehurst 1994).

officer wrote a thesis based on work at Oenpelli in which he stated,

*The Gunwinggu people do not have a word for health. The closest equivalents are strong, not sick, happy and feeling good. Those Aborigines who were fluent in English said good health means ... Gamak, or 'happy with my people' and Gamak Rowk, or 'feeling good during and after ceremonies' (Soong 1981).*

It was not long before the Aboriginal community-controlled health services took up the theme that health had broad interpretations for Aboriginal people. Two years later, a report commissioned by Congress, the Aboriginal community-controlled health service in Alice Springs reiterated: 'It is interesting to note that Aborigines do not have terms for 'health' or 'healthy'. The closest Aranda equivalent to 'healthy' is *mwarre*, which means 'good' or 'well' in a much wider sense'(Nathan and Japanangka 1983, p.18). Gatjil Djerrkura's original 1981 statement found its way eight years later (albeit in an elaborated, newly invented form and with its origins unacknowledged) into the introduction to the National Aboriginal Health Strategy report where it was reformulated as 'life is health is life'. This Aboriginal definition is linked by the authors to that of WHO.

## **6.2. Explicit and implicit motivations**

It was necessary to promote the idea of indigenous conceptualisations of health in order to bring about a balance between Western medical practice and sensitivity to Aboriginal needs which simply did not exist before - a state of affairs highlighted by Kamien's work cited at the beginning of this chapter. But it is undeniable that the promotion of Aboriginal views on health has also had conscious, political motives. The emphasis on the difference in perspectives about what health means to Aboriginal people has been used for both radical and conservative ends. It was used by Aboriginal health activists in their determination to challenge the status quo, to argue for greater Aboriginal control of health resources, and to legitimise continued funding for special services on the grounds of Aboriginal cultural difference. As I have shown, the spirit (if not the wording), of Gatjil Djerrkurra's announcement of the Aboriginal conceptualisation of health was re-

invented and reformulated by the authors of the National Aboriginal Health Strategy. From that time, as a result of constant repetition it has passed into the realm of received wisdom - indeed, it has *become tradition* (Hobsbawm 1996). It is now accepted and is officially reproduced as a valid expression of pan-Aboriginal thinking on health. The irony is that the invention was initially promoted by a conservative government.<sup>23</sup> The Aboriginal conceptualisation of health was used by the Territory government as a means of placing responsibility for health back onto the communities themselves, by stressing that health for Aboriginal people *really* meant 'life'. By so doing, the Territory government de-emphasised its own responsibility to deliver professionally-run clinically-based health services to deal with those illnesses which are amenable to medical intervention.

## Conclusions

The issues discussed here highlight an inherent contradiction in the WHO principles of primary health care - that primary health care should intimately involve lay people, community members, as well as being based on scientifically-sound medicine. The tension between these two elements in the idealised version of primary health care is illustrated in this chapter by the debate on literacy for Aboriginal health workers. This tension is also a theme apparent in the discourse of Aboriginal health activists who deflated the role of the professional medical practitioner, while elevating the role of the para-professional, the representative of the people, the 'barefoot doctor', the Aboriginal health worker. The discussion here has also explained how the WHO definition became incorporated in an increasingly sophisticated argument for the acceptance of cultural differences as a key issue in the struggle between governments and the indigenous health movement. The impact of the elucidation of difference on national policies is pursued in the following chapter.

---

<sup>23</sup> Indeed, it continues to be used by conservative governments. In 1999 Senator John Herron, Minister for Aboriginal and Torres Strait Islander Affairs in the Coalition government led by John Howard, presented the Bancroft Oration which he titled 'The Future of Indigenous Health - the Union of Body and Soul' (Herron 1999). He cited Plato and the National Aboriginal Health Strategy.

## CHAPTER THREE

---

### Difference and indifference in national policies

*In the last two chapters I traced the way in which the UN and WHO have played an influential role in legitimising Aboriginal assertions of difference and in strengthening Aboriginal demands that they play an active part in running their own health services. In this chapter, by examining the place of Aborigines in national policy documents in the health portfolio I show how the growing separation of domains, together with an increased sensitivity to Aboriginal difference, affected these policies.*

#### 1. Making national policies

Policy-making has been located as a new field for anthropological enquiry, inviting questions such as how policies work as instruments of governance, and how major shifts of discourse are made authoritative (Shore and Wright 1997a; Shore and Wright 1997b). Policy increasingly shapes the way in which individuals construct themselves as subjects. Furthermore, policy *fragments* on closer examination, as Shore and Wright point out. It may be found in the language and rhetoric of political speeches, in the written documents produced by governments, the mechanisms of service delivery, and even in whatever people experience in their interactions at the grassroots with bureaucrats (Shore and Wright 1997b, p.5). The policy documents analysed here emerged at a time when the Aboriginal health movement was increasingly demanding input into the national arena, but was simultaneously emphasising the need for special and separate consideration of Aboriginal health issues - an emphasis which posed considerable problems for national policy makers.

Australia has an international reputation for its progressive national policies in health. However, national policy-makers have become increasingly uncertain about how they should deal with indigenous issues within these overarching frameworks and principles for action. Throughout the

1980s greater emphasis on Aboriginal exceptionalism resulted in what amounted to virtual exclusion of their interests and special needs from mainstream documents. This, I argue, has been the case in three major policy areas: HIV/AIDS, alcohol, and health. While there are complex reasons for the scant attention to detail when it came to indigenous people, three in particular stand out. First, Aborigines are considered to require special treatment because of cultural differences; second, since the 1967 referendum, Aboriginal issues have fallen victim to Commonwealth/State wrangling; and third, there was a failure to produce a national Aboriginal health policy.

The 1980s saw the production of several major national reports on health. In 1988 an important national report was published entitled *Health for All Australians*, which provided the first attempt in Australia to compile national goals and targets for reducing inequalities in health status among population groups. Also in 1988 the government published its first Policy Discussion Paper on HIV/AIDS, *AIDS: A Time to Care, a Time to Act*, which provided proposals towards a national strategy (Commonwealth of Australia 1988). In the drug and alcohol field, a National Campaign Against Drug Abuse was launched in 1985, stimulating research, prevention activities and increasing public awareness. In 1989 the National Health Policy on Alcohol was agreed to by the Ministerial Council on Drug Strategy, which declared a national commitment to harm minimisation. Each of these documents or initiatives was, in its own way, ground-breaking. Each one tackled the Aboriginal and Torres Strait Islander component of the population in varying degrees of detail.

I begin by outlining developments in the national 'better health' program. I then examine the fate of what was intended to be a special national health policy for indigenous people. Two further case studies follow: the first examines the major reports on HIV/AIDS in Australia and the uncertain place of Aboriginal people in them. The second case study is on alcohol policies and the National Campaign against Drug Abuse.

## **2. National health goals and policies in Australia**

In 1981, the World Health Organization developed a global strategy for attaining health for all by the year 2000, which was founded on the concept of country-wide health systems based on primary health care (Department of Community Services and Health 1988). Member states were asked to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of their comprehensive national health systems. As a result of this international initiative, and in order to fulfil its obligations as a signatory to it, the Australian government established a committee to develop a set of health goals and targets for Australia for the year 2000. The committee's initial report, *Health for All Australians*, published in 1988, was a comprehensive document discussing and establishing goals and targets for improvements in health, with a strong emphasis on risk factors and preventive programs (Health Targets and Implementation Committee 1988). Since then a revised edition has been published (in 1993), together with draft papers on four focus areas (cardiovascular disease, cancers, injury and mental health). In 1993 it was agreed that Australia would work towards a National Health Policy, a shared policy framework for the Australian health system, and this decision was endorsed by Commonwealth, State and Territory governments. Its central themes are the development of key strategies to improve health outcomes and the development of information systems which support an outcomes approach to resource allocation (Department of Human Services and Health 1994, p.9). Altogether these documents provide a substantial body of knowledge, and demonstrate a major national effort to improve health outcomes.

*Health for All Australians* made recommendations for priority program areas, but omitted several important issues such as HIV/AIDS, drugs and alcohol, on the grounds that these were to be the focus of other special national projects. Also omitted for the same reasons was Aboriginal health. It was intended that a comprehensive Aboriginal national policy on health would be developed during 1988 and that health goals and targets would be set by 1989. 'Because this national process has already commenced', the report states, 'the Committee did not consider it appropriate either to develop new goals and targets or to endorse goals and targets set by existing bodies' (Health Targets and Implementation Committee 1988, p.30). In fact, no Aboriginal health policy as such

was forthcoming, and the process of establishing Aboriginal national goals and targets encountered political difficulties.

### **3. Whatever happened to the Aboriginal Health Policy? A case study**

The fate of the proposed national Aboriginal health policy was decided at a meeting of Aboriginal affairs Ministers held in Cairns in 1986. Aboriginal health funding was at that time administered by DAA, with the Commonwealth Department of Health (CDH) ostensibly having a policy advice role (Holding 1985). The CDH, through the Minister for Health, Dr Neil Blewett, offered to fund a task force on Aboriginal health which was to formulate a national policy in conjunction with NAIHO, the national lobby group representing the Aboriginal community-controlled health services. NAIHO was to be invited onto the task force. The Department anticipated and offered an expenditure of \$880,000 over an eighteen month period for this process. This proposal was brought to a meeting of the Australian Aboriginal Affairs Council (AAAC) held in June 1986 in Cairns, where the Commonwealth hoped to gauge the reaction of State and Territory governments, and to achieve a reaffirmation of the need for a national Aboriginal health policy. Dr Blewett was to discuss the proposal separately with Health Ministers from the States and Territories.

Prior to the Ministers' meeting, departmental officers met to thrash out the proposal. While endorsing the proposal for a nationally agreed Aboriginal policy, a New South Wales staffer questioned whether there was a need for a task force to take eighteen months to produce such a policy. It was asserted that the data to produce a policy already existed, that a task force would delay its implementation, and that the matter was too urgent to wait. After a brief discussion, a tentative recommendation (without unanimous support) was made to the Ministerial Council that a task force should be established and that there would be cooperation to develop national goals and strategies.<sup>1</sup> At the meeting of Ministers which followed, the Commonwealth was represented by Clyde Holding, the Minister for Aboriginal Affairs. The proposal immediately ran into serious disagreement between the Ministers. The New South Wales Minister pursued the argument put forward by his departmental officer the day before:

---

<sup>1</sup> Standing Committee of Officers meeting 25 June 1986. F354.94063 AUS (ABOR).

*If we needed to take eighteen months to have a task force and spend \$880,000 on that task force to develop a national policy, then I really wonder what has been going on over the last few years. The health experts and people in Aboriginal affairs ought to be able to develop that policy. I am not trying to shift that responsibility onto the Commonwealth, I just believe it is in a better position than anybody to prepare that initial paper.*<sup>2</sup>

Bob Katter (Queensland), who chaired the meeting, interpreted the suggestion for a national Aboriginal health policy as being a move to over-ride States' rights, on the assumption that such a policy would seek to endorse the development of separate community-controlled health services. The Queensland government perceived these to be a 'disastrous failure' providing 'second-rate services', and to which it was ideologically opposed. Katter asserted that policy should be made by the States themselves. Peter Anderson (NSW) hurriedly explained that such a policy would not dictate the details of service delivery but establish priority health problem areas and recommend strategies for dealing with them on a national basis:

*I am not suggesting that a national Aboriginal health policy will say to every State and Territory: "This is how you will deal with this problem and in this order". That is not what I am suggesting at all. Given all the research that is being done, the issues that have been identified and the different ways in which it has been approached across Australia in the different jurisdictions, our objective is now recognised. That information gives us the opportunity ... to know what has happened in the past, what needs to be done by the identification of those needs, how it can be achieved, and then determine by what mechanism that targeted objective will be achieved. I do not see this in any way as being used as a tool to infringe upon State rights (Proceedings: 68).*

Having averted further disagreement on the basis of 'State rights', the discussion then turned to terminology. Ray Groom from Tasmania asked whether it would be better to use the term 'strategy' rather than 'policy'. Holding amended the item to read:

---

<sup>2</sup> P. Anderson, AAAC Proceedings 27 June 1986:65. F354.94063.AUS (ABOR).

*... this strategy be accompanied by a priority list of State and Territory projects to be considered for funding by relevant Commonwealth and State agencies consistent with the above strategy.*

A discussion ensued:

*Holding: are we using the term 'policy' or the term 'strategy'? I do not mind which we use*

*Anderson: What about 'strategic policy'?*

*Holding: I do not mind which term is used.*

*Anderson: I do not mind. The intention is the important factor (Proceedings: 70).*

The Ministers continued to use the terms interchangeably in a discussion about the degree to which the Commonwealth needed to be involved. Anderson (NSW) stressed the need for a national commitment and then agreed that strategy was a better word than policy. In the end, the resolution (item 6) read: 'to affirm the need for a National Aboriginal Health Strategy'. A draft was to be drawn up by CDH and DAA for circulation to peak Aboriginal health councils and the States/Territory within three months. But the final clause reveals confusion to the end. It reads:

*'(d) (ii) this policy be accompanied by a priority list of State and Territory projects to be considered for funding by relevant Commonwealth and States/Territory agencies consistent with the above strategy' (emphasis added).*

When the Ministers for Aboriginal Affairs and Health finally agreed to the establishment of a working party - presumably the renamed 'task force' - it was in December 1987, eighteen months later, and the working party was to write a *strategy*, not a policy. Even then, the National Aboriginal Health Strategy Working Party (NAHSPWP) term of reference (e) notes that it should

*...develop a mechanism to monitor progress towards achieving targets, taking into account performance indicators developed as part of the policy (National Aboriginal Health Strategy Working Party 1989, p.xix)*

Even after the working party report had been submitted in 1989, the joint press statement which was issued by the Ministers for Health and Aboriginal Affairs (Neil Blewett and Gerry Hand) continued - extraordinarily - to blur 'strategy' with 'policy'. The statement reads:

*The Working Party was established by the Commonwealth, States and the Territory in December 1987 to develop an agreed national Aboriginal health strategy. It is the first time the Commonwealth, State and Territory Governments, as well as Aboriginal and Torres Strait Islander community representatives have worked together on a national health policy (Joint Press Release 22 March 1989, emphasis added).*

The account of this meeting highlights several of the ongoing problems associated with the administration of Aboriginal health : the issue of States' rights and the resistance of the States to suggestions that the Federal government should have a guiding role; the intra-government dispersal of responsibility for Aboriginal health shared at a Commonwealth level by both Aboriginal Affairs and Health portfolios; the belief that 'too much' research had already been done; and the perceived urgency of the situation leading to an expedient rushed approach. Finally, there was a failure to distinguish between policy-making - providing an overall expert framework - and the strategic *implementation* of policy. It is not a quibble to suggest that substituting 'strategy' for 'policy' was an error. A policy is a '*course or line of action* adopted and pursued by a government, ruler, political party, or the like' (Macquarie Dictionary). A strategy is the 'skilful management in ... attaining an end; a *method of conducting operations* especially by the aid of manoeuvring or stratagem'. This distinction is recognised in other Commonwealth documents on Aboriginal issues.<sup>3</sup> The degree of argument among Ministers is also indicative of their perception of policy-making as a tool with which to regulate the population from the top down: an instrumentalist view of government.

---

<sup>3</sup> In 1987 the Federal government issued five policy papers on Aboriginal employment which provided overall goals, noted the need for ongoing refinement of objectives, and set a date for an independent review after five years. The paper clearly distinguished between its policy and the strategies framed to achieve it (Australian Government 1987).

### **3.1. The National Aboriginal Health Strategy report**

The National Aboriginal Health Strategy Working Party was chaired by the administrator of the Aboriginal Medical Service in Redfern Sydney, the first of the community-controlled services to be established. The working party travelled and consulted widely, received submissions and held meetings across the country in 1988 and 1989. The document produced by the Working Party provides a useful overview of Aboriginal health problems and the steps already taken, or which should be taken, to ameliorate them. It made a serious attempt to elicit inter-sectoral collaboration. Nevertheless a policy - if one had been produced - should recommend an overall framework as a means of guiding programs. For example, such a policy could decide to focus on a major theme, such as the major causes of excess mortality borne by Aboriginal people. It could take as a principle the notion of avoidable deaths - that is deaths from conditions which should be amenable to prevention by adequate medical care - and provide guidelines for service delivery that would deal with these. This approach has been used widely to develop indicators of health service outcomes (Australian Institute of Health and Welfare 1994; Rutstein, Berenberg, and Chalmers 1976). In contrast, the Strategy did not communicate any sense of urgency to prioritise key issues; it did not even prioritise its recommendations. The disease specific strategies are general, and the Working Party did not focus on implementation or on core strategies for health improvement. As it was, in the end, described as a strategy this is an embarrassing outcome (Anderson 1997a; Hogg 1995; Saggers and Gray 1991).<sup>4</sup> Its report had to be referred to a committee to advise on implementation, the Aboriginal Health Development Group (Gordon 1994).<sup>5</sup> While this was interpreted by some in the Aboriginal health movement as a political ploy by the government to

---

<sup>4</sup> An obvious subject for a much more targeted approach would have been circulatory system diseases, particularly heart disease, which is responsible for 50 percent of the excess risk of death between Aboriginal and non-Aboriginal people (Hogg 1995; cf Gray 1990; Kunitz 1994). Hogg and others have pointed out that this extraordinarily high death rate from heart disease in middle age is anomalous, and does not accord with health transition theory. This predicts that when life expectancy is as low as this, the causes would normally be infectious and parasitic diseases associated with childbirth and early childhood. This is *not* the case in Australia.

<sup>5</sup> The Aboriginal Health Development Group makes further, veiled criticisms of it which relate primarily to the lack of definitive comment or detailed recommendations - for example on the prioritisation of its recommendations, the composition of the recommended Council for Aboriginal Health, and of the proposed Office of Aboriginal Health to be set up within ATSIC (Aboriginal Health Development Group 1989). It seems that overall the Working Party was not well-managed. One bureaucrat involved in the NAHS project reported that the final document was prepared in haste over several weekends to meet the deadline (Pers.comm. Robert Hall).

shelve the report, in reality it was an attempt to try and extract some core strategies from the uneven structure of the report.<sup>6</sup>

There are other anomalies in the report, including a tension between promoting a holistic, Aboriginal/WHO definition of health, and a relative emphasis on key diseases (Anderson 1997a). The Working Party was chaired by Naomi Mayers, administrator of the AMS in Redfern, the leading and most politically active Aboriginal health service, and the impetus behind NAIHO.<sup>7</sup> As shown in the previous chapter, the Aboriginal community-controlled health services consistently stressed the role of primary health care, and the control of the health service by 'the community' rather than by the medical staff. This was in keeping with the ideology of the AMSs since their inception, reinforced by Alma-Ata and the WHO definition of health - the latter received a prominent position at the opening of the Working Party report. The deflation of the role of medical professionals in Aboriginal health was accompanied by a stress on holistic health, on the social, historical and environmental influences on health. The Aboriginal health movement was ideologically opposed to a specialised focus on disease, which has been conceptualised as dividing people into 'body-parts'. This 'body-parts' approach is interpreted as being antithetical to holism.<sup>8</sup> Despite this, one chapter in the report is devoted to specific disease categories and briefly lists separate strategies appropriate to each. On the other hand, the Working Party was keen to emphasise socio-economic and environmental issues rather than 'diseases'. This is revealed in its discussion on the role of the National Health and Medical Research Council (NHMRC) in Aboriginal health research. The Working Party (National Aboriginal Health

---

<sup>6</sup> The Commonwealth allocated \$232m over five years for the implementation of the NAHS, the majority of which was to be spent on housing and essential services. While this focus on environmental issues and 'health hardware' was long overdue, it begs the question of relevance to the urban Aboriginal populations, where infrastructure is of better quality. Despite this, the health of urban Indigenous people is often not measurably better than that of people living in remote, environmentally disadvantaged communities. There are exceptions of course, such as the infant mortality rate being highest in the more remote areas (Thomson 1990). The NAHS was evaluated in 1994 (Gordon 1994).

<sup>7</sup> Redfern still maintains a strong influence, as Ms Mayers continues (as at 1999) to be a key office-bearer of NACCHO (National Aboriginal Community Controlled Health Organisation) the successor to NAIHO.

<sup>8</sup> In 1999 NACCHO through its chairman endorsed a publication on an evidence-based approach to Aboriginal primary health care, which contains chapters on different disease categories (rheumatic fever, diabetes, renal failure, ear health and so on). It is ironic that after many years of protesting about the biomedical 'body-parts' approach to Aboriginal health, NACCHO has apparently accepted the need for systematic reviews of 'evidence-based medicine' such as this (Couzos and Murray 1999).

Strategy Working Party 1989, p.217) made the following statement:

*The Working Party recognises that there should not be an imbalance towards areas of research in specific diseases. Rather it is recognised that there should be a swing towards a balancing emphasis on Social Health and the socio-economic and consequent mental stress basis for illness within Aboriginal communities.*

In fact, as Johansson explains, each aspect of a ‘holistic’ multi-faceted definition of health has its place, for

*...accepting complexity is consistent with the idea that ‘health’ has no single definition because it is at once biological, medical and political, economic, social and cultural. Which aspect of health is most important for solving a particular problem depends on the context in which a health problem appears. Some are best approached from a bio-medical perspective and others from a political, economic or cultural perspective, but no one perspective excludes the others (Johansson 1995, p.299)*

#### **4. National HIV/AIDS research and programs: a case study**

The first major report on HIV/AIDS in Australia *AIDS: A Time to Care, A Time to Act* (1988) successfully but briefly identified some of the key issues for Aboriginal groups. The report stressed that ‘culturally specific and appropriate’ measures were needed, acknowledged that there were some ‘sensitive’ aspects to traditional culture, and noted that successful programs should be negotiated locally so as to fit with particular audiences, and drew attention to the need to distinguish ‘isolated’ from ‘fringe-dwelling and urban’ groups. (Commonwealth of Australia 1988, p.137-8) The report expressed the view - in phraseology which has become a familiar ‘motherhood statement,’ for dealing with indigenous issues in national policy documents - as follows:

*...culturally specific and appropriate measures are needed to minimise HIV infection among Aboriginal and Islander people ... Traditional Aboriginal concepts of disease, and*

*Aboriginal learning and communication styles, differ (Commonwealth of Australia 1988, p.137).*

As the Commonwealth's campaign became more focused in the ensuing years, and education strategies were devised based on carefully-conducted research, the gap began to widen between the expert direction of policy and program planning for the whole population, and that given to the Aboriginal population.

#### **4.1. HIV/AIDS knowledge, attitudes and behaviours**

A major feature of Australia's approach to the HIV/AIDS epidemic was raising public awareness and educating specific at-risk groups in the population. A prerequisite for *any* education campaign, whether media-based or otherwise, is to establish baseline data on knowledge, attitudes and behaviours so as to better target the audience, and aim to fill gaps in knowledge. In 1986 when the National Advisory Committee in AIDS (NACAIDS) commissioned the first qualitative and quantitative studies in order to guide the design of its public awareness campaign and to establish benchmarks, it did not include populations such as Aborigines and Torres Strait Islanders. Of necessity it was a comprehensive national study of knowledge, attitudes and behaviours focusing on general target groups (adults, adolescents, gay men, intravenous drug users). The extensive research base which this provided guided the national AIDS media campaign.

Indigenous people received separate (and brief) treatment in the *National HIV/AIDS Strategy* (the 'white paper') (Department of Community Services and Health 1989). They had different advisory structures (the Communicable Diseases Advisory Panel and ATSIC) and a separate appropriation of money. Education, it was said, must be designed to meet the needs of the local community. The first published government paper to deal with indigenous approaches to HIV/AIDS was a Consultation Paper published in 1989 (Working Panel on Aboriginals 1989). The Consultation Paper gave an overview of educational activities emanating from several widely-dispersed regions: Redfern, Yarrabah and Alice Springs, and the 'Story in our Hands' program established by the Northern Territory government. In this document media-related

strategies were not addressed in any detail, and nor was mention made of the need for baseline research into knowledge, attitudes and behaviours. While the document pointed to the familiar confusions over funding sources it compounded these by recommending that the funding for community grants should be transferred from CDH to the Aboriginal Affairs portfolio, further separating Aboriginal HIV/AIDS programs from those in the mainstream. It appears that this recommendation was decided upon in order to 'comply with the general thrust of the National Aboriginal Health Strategy' which had recommended that the Aboriginal health function remain within the portfolio responsibility of the Minister for Aboriginal Affairs (Working Panel on Aboriginals 1989, p.10).

Despite the fact that the national reports were intended to be broad-based documents, their recommendations ensured that some specific groups were targeted and that in-depth research was conducted on knowledge, attitudes and behaviour. An outstanding example was a report on *Women and HIV/AIDS Education in Australia* (Gallois, Statham, and Smith 1992). This commissioned report provided a thoughtful and critical analysis of the most useful literature in Australia and internationally. It detailed specific strategies such as the health belief models as they apply to HIV prevention (factors predicting whether or not an individual will engage in health promoting behaviour), the extent to which peer groups support safe sex, and the need to know how men and women negotiate sexual and social encounters. They stressed that in order to change behaviours towards safe sex, AIDS educators must know the present practices of the women they are targeting. Gallois and colleagues were openly critical about the 'paucity of research with Aboriginal and Torres Strait Islander women on knowledge, attitudes, behaviours and practice', saying that this was an important gap in the literature (Gallois, Statham, and Smith 1992, p.22). They were unable to find a single reference on Aboriginal people from which to quote It is probably true to say that there is more information about the knowledge, attitudes and behaviours among sub-groups *other* than Aboriginal people. Gallois and colleagues were able to cite research on migrant groups noting lack of fluency in English and its effects on lack of knowledge, and the important finding that that for some migrants, differentiation of 'their' group from the wider Anglo-Australian society led people to believe that AIDS was less of a threat to them (Gallois,

Statham, and Smith 1992, p.24). This may be the case among Aboriginal or Torres Strait Islander groups as well, but there is only anecdotal evidence of it.<sup>9</sup>

The report *AIDS: A Time to Care* had recommended in 1988 that 'research about each target group needs to be undertaken to provide data on the prevalence of risk behaviour' (Commonwealth of Australia 1988, p.103) but this did not occur on any systematic basis among Aboriginal and Torres Strait Islander people. Instead, there were scattered local studies of knowledge, attitudes and behaviours, some with very small sample groups. These include Rowse who interviewed a small group of traditionally-oriented Central Australian men, and Streetwize Comix, who undertook pre-production research for one of their comic-book health education productions 'Bushwize' aimed at Central Australian Aborigines (Rowse 1996; Rowse nd). (Streetwize found some useful information including the reluctance to use condoms, high risk sex associated with alcohol use, and limited intravenous drug use (Mohr, Schaber, and Whitty nd). The Kimberley Aboriginal Medical Services Council, centred in Broome, surveyed 232 people in several different communities in the Kimberley, discovering key gaps in knowledge, several areas of misunderstanding about HIV infection, (including the belief that washing yourself after sex would protect from AIDS), and limited use of condoms (Brady 1994). A questionnaire administered to 63 Aboriginal people in Central Australia by Congress found gaps in knowledge about transmission and infrequent use of condoms (Torzillo and Kerr 1991). These studies were undoubtedly conducted under extremely difficult circumstances and provide vital information; but they are largely unpublished, and were not informed by any strategic plan.

There was further concern expressed in a Commonwealth document in 1992. The authors of a report taking stock of the National Strategy had to report that they were provided with insufficient information to make an 'adequate assessment' of implementation of the National Strategy as it relates to Aboriginal and Torres Strait Islander people (Department of Health Housing and Community Services 1992, p.35). Their task was to focus on jointly-funded Commonwealth and

---

<sup>9</sup> Several Aboriginal-produced posters carried wording which said that 'white people,' brought AIDS from overseas, which may carry with it the implication that AIDS is a 'whites' disease. On the issue of facilitating strategic planning, there are examples from overseas of indigenous groups being assessed for their knowledge, attitudes and behaviours, for example among northwestern American Indians (Hall et al 1990) and in developing countries (Schopper 1990).

States/Territories activities under a matched funding program. Here, on the issue of funding, the Committee also expressed familiar concerns, opining that funding for Aboriginal health educators was drawn from several different sources, that there were disparities between States and Territories in the degree of priority given to Aboriginal projects, and that the funding devoted to Aboriginal populations 'does not reflect the relative size of these communities in the various States' (Department of Health Housing and Community Services 1992; National Evaluation Steering Committee 1993). In most cases, the salaries of indigenous AIDS educators have been reliant on one-off short term Commonwealth grants; this has resulted in lack of continuity. These concerns were not elaborated further.

Evaluation reports noted as a general achievement that there were significant gains made in increasing Aboriginal knowledge and prevention as well as the increasing openness in discussing sensitive issues such as sexual and ceremonial activities. However, the concerns raised above present a worrying picture: the lack of systematic baseline studies of knowledge, attitudes and behaviours among indigenous people; the lack of reliable epidemiological data; the separation of structures for dealing with Aboriginal HIV/AIDS management; the problems with funding arrangements. These are significant matters considering that there is a potential for HIV to spread rapidly in Aboriginal and Torres Strait Islander populations. Health and living standards are usually lower than those of Anglo-Australians, there is a high prevalence of STDs (recognised as co-factors in HIV infection), and high levels of alcohol abuse. There is also a high rate of imprisonment, presenting further risk of exposure to HIV.

#### **4.2. Cultural appropriateness vs best practice**

Considerable weight has been placed on the need for *local*, community-based knowledge to drive HIV/AIDS prevention for indigenous Australians. Such an emphasis is, of course, particularly appropriate for this unusually intimate and sensitive health matter. There is more to it than this, however, and the emphasis on local, culturally-specific and community-based work also came about because of the burgeoning awareness and acceptance of difference and of Aboriginal demands for 'culturally appropriate' approaches. Factors such as the variety of social organisation and ceremonial practices, and variation in living conditions and sexual mores across the country

indicate the requirement for approaches to HIV/AIDS to be tailored to suit particular needs in different locations. Dealing with HIV/AIDS and Aboriginal people was undoubtedly a politically volatile endeavour - some early publications from Aboriginal health activists accused national AIDS bureaucrats of scapegoating Aborigines by drawing attention to the potential for traditional initiation practices (involving cutting the skin and exchanging blood) to facilitate the spread of the HIV virus (Newfong 1989). The existence of these (exotic) ceremonial activities and of the elaborate separation of male and female domains in parts of the country undoubtedly exacerbated a bureaucratic fear of making cultural blunders. There are also dangers in a 'culturalist discourse' (particularly in the case of HIV/AIDS) or a reliance on cultural relativism in order to explain difficulties in health promotion or intervention. As Seidel and Vidal point out, such a reliance ignores people's capacity to change, and underestimates the factors which do not explicitly derive from cultural tradition (Seidel and Vidal 1997).

The first poster produced for Aboriginal audiences in 1986 (designed by a Darwin-based Aboriginal worker at the Menzies School of Health Research) is one example of the tension between what was thought to be 'culturally appropriate' and the need for best advice. The poster depicted the AIDS virus as a green monster figure, urged people to use condoms and to throw used condoms in their fires. In much the same way as some of the health education attempts described by Foster as long ago as 1965 (Foster 1965)<sup>10</sup>, the poster went badly wrong. The advice to burn condoms in the fire was inappropriate for those Aboriginal groups for whom the fire is kept clean for direct cooking of food; rubbish is never burned in such fires. The green monster, as it turned out, caused fear and misunderstanding:

*Following the AIDS stickers and posters depicting the virus as a Green Devil (mamu) one person fled his home, with both himself and the community believing that his sores with their green purulent discharge must be AIDS. Misinformation is more dangerous than no information at all! (Nganampa Health Council 1988, p.52)*

---

<sup>10</sup> Among Foster's illustrative vignettes, he describes the US Navy attempting to run a fly-borne disease campaign in the Pacific using a foot-long model of a house fly. The local chief agreed that the Americans must be very preoccupied about flies because they were so big, but that the ones they had on their island were only little ones (Foster 1965).

In this case, the advice was given (to use and dispose of condoms), but it was culturally inaccurate. Another series of posters, from South Australia, showed local Aborigines playing football with the message 'AIDS is a killer - there is no cure, so play it safe', and featuring a gravestone. The posters failed to provide practical information about using condoms or seeking help, as well as inexplicably linking playing sport with AIDS. Condoms had not been mentioned because this would have offended a Christian board member of the Aboriginal health service involved, who had ruled out the advertising of condoms on their posters. In this case, not giving offence to an Aboriginal board member was given precedence over providing best practice advice (Brady 1994).<sup>11</sup>

The national HIV/AIDS policy and the funding agencies channelling grant monies to regions and communities were initially unable to guide local Aboriginal community-based approaches. They did not, for example, make funding conditional on a number of bottom line 'best practice' guidelines to which *all* prevention activities should subscribe<sup>12</sup>. It was assumed - incorrectly - that cultural identification would be enough (Hill and Murphy 1992). As a result of the absence of professional guidelines, as well as the absence of any preliminary research which targeted the level and scope of Aboriginal knowledge, attitudes and behaviours, several of the early locally-devised activities may indeed have been 'culturally appropriate' but lacking expert advice, they produced questionable outcomes.<sup>13</sup> Ironically, one of the most successful images constructed for Aboriginal HIV/AIDS awareness is not 'culturally appropriate' at all in the usual sense of bearing Aboriginal symbols and iconography. In 1986 an Aboriginal health service in the Kimberley (BRAMS) created a strip comic story based on the Phantom, called 'How Wanda said no in

---

<sup>11</sup> There was a plethora of poster-production, both by professional Aboriginal artists and by local communities on HIV/AIDS in the 1980s and early 1990s and many of them were subject to the same problem. A series of three posters by urban Aboriginal artist Bronwyn Bancroft was commissioned by the Commonwealth Department of Health, and had three print runs. A total of 120,000 were widely distributed but they received a mixed reaction from remote communities, where residents had trouble understanding what message their very abstract designs were communicating. They too gave neither practical advice nor provided phone numbers for further information (Brady 1994).

<sup>12</sup> For example: always give advice, show condoms, provide contact phone numbers, stress that the disease is not racially discriminating, avoid doom and gloom messages.

<sup>13</sup> Later Aboriginal productions have successfully blended local mores of cultural appropriateness with expert advice. For example in 1994 the NPY Women's Council (covering lands in the far north-west of South Australia) produced a women-only video. It utilised a variety of techniques including story-telling, animation and direct face-to-camera by local women. It showed women discussing how to negotiate safe sex with partners. Other successful prevention and research activities are documented in the National Indigenous Sexual Health Strategy 1996-97 to 1998-99 (ANCARD Working Party 1997).

Broome'. Phantom comics are very popular among young Aboriginal people. A modified Phantom figure emerged as 'Condoman' promoting the use of condoms without 'shame', as a result of a collaborative exercise between public relations experts in the Commonwealth Department of Health and Aboriginal health workers. While Condoman is instantly recognisable and accepted across the country he is in no way 'traditional', bears no resemblance (other than being black) to anything 'Aboriginal', and is a universal rather than a culturally-specific icon (Hill 1996). The sale of condoms is also promoted in Papua New Guinea using the Phantom (Hughes 1994).

Despite the success of the collaboration between the CDH and Aboriginal groups which produced quality advice and artwork for health promotion (including 'Condoman'), community-controlled organisations at this time were equivocal about the involvement of professionals as equal partners in health promotion enterprises. For example, having successfully produced a series of videos on AIDS, some combined health services in Central Australia made the following statement:

*Anyone can produce videos but the effectiveness of their use is determined by Aboriginal people themselves. The following may be worth considering:*

- 1. Non-Aboriginal people should act as facilitators with minimal influence on ideas and content. Providing accurate information is recognised as necessary but only with an understanding and working experience of Aboriginal culture.*
- 2. It is essential Aboriginal people are involved from the concept to final stages of production of both the project content and the technical skills required to complete the production.*

*(Combined Central Australian Health Services 1989)*

This position leaves unresolved the question of best practice, while privileging local knowledge and community involvement. It also leaves unresolved the fact that all *other* sections of the Australian population were the subject of careful enquiry into the knowledge, attitudes and behaviours surrounding HIV/AIDS, so that educational media have been formulated accordingly.

The official position on media (Department of Community Services and Health 1991, p.4) was that,

*...whatever media are used, research, focus testing and evaluation of all media strategies for particular groups and the general public are essential for the development of an overall communication strategy for HIV/AIDS education. This is done through campaign-specific research used in determining target groups and designing the material, focus testing of the material (which in turn shapes the final product), tracking studies and post campaign evaluation. This includes recognition and recall studies and measurement of attitudinal change as a result of the campaign.*

While it is necessary for the production and delivery of HIV/AIDS prevention programs for indigenous people to be achieved locally or regionally, this should not serve to deny these populations the best research and knowledge dissemination techniques which the larger Australian population enjoy. The competing demands for indigenous involvement in the productions, and for accurate information, provide a good illustration of the difficulties of putting into practice the Alma-Ata declaration urging 'socially acceptable' and 'scientifically sound' methods and technology in primary health care. It was not until 1997 (more than ten years after the first attempt to devise culturally-specific AIDS education for indigenous people) that a substantial national report on indigenous sexual health squarely faced the need for clinical and educational components of the strategy to be integrated with cultural relevance and appropriateness. The indigenous Australians' Sexual Health Strategy insisted that while the shift to a 'horizontal' approach embedded in a primary health care framework was entirely necessary, it was equally important to retain elements of a 'vertical' approach which included national coordination and leadership, an evidence-based framework and good information systems (ANCARD Working Party 1997).

## **5. National Drug and Alcohol Policies: a case study**

As with its national health policies, Australia paid attention to the directives of the World Health Organisation on national alcohol and other drug policies. In 1983 WHO at its 36th Assembly

urged member states to formulate comprehensive national alcohol policies ‘with preventive measures as a priority, and with *attention to populations at special risk*, within the framework of the strategy of health for all’ (Department of Community Services and Health 1988, p. 85; Lewis 1992a; Room 1984a). WHO also urged the development of coordinated programs on a planned, continuous and long-term basis. Australia became, in fact, something of a world leader in its policies and their implementation.

Lewis provides a comprehensive overview of Australia’s alcohol policies and this is not the occasion on which to deal in detail with the history of Australia’s changing perceptions of alcohol problems (Lewis 1988; Lewis 1992a; Lewis 1992b). Briefly, efforts in Australia (as elsewhere) had historically focused on narrow policies of rehabilitating individual casualties of alcohol abuse. The 1970s brought a gradual shift in perspective - influenced by WHO (Room 1984a), the work of alcohol researchers and by doctors working in the treatment area - who helped to promote a wider political and economic perspective. They lobbied for research to be transformed into policy and practice (Kingdon 1993). Lewis draws attention to the value of leading international thinkers in alcohol research (such as Kettil Bruun) and the small but articulate group of expert doctors in Australia (such as Alex Wodak, Aiden Foy and J.N. Santamaria) who were so significant as lobbyists in the struggle to force Australian governments to adopt policies lowering consumption. Wodak also frequently urged the involvement of the medical profession in alcohol policy issues.

They succeeded in shifting the emphasis from the individual to notions of overall prevention and legislative controls.<sup>14</sup> The watershed in Australia’s position on alcohol policy came about in 1977 when the Senate Standing Committee on Social Welfare (chaired by Senator Peter Baume) for the first time investigated the use of alcohol and tobacco and not just illegal drugs, and examined alcohol in its social and economic context and how these influenced policy decisions. Lewis concludes that ‘it made a singularly important contribution to the discussion of alcohol policy in this country’ (Lewis 1992a, p.175). In 1980, the committee’s recommendations led to a policy statement on alcohol (although not to specific goals) which was health-oriented, favoured the lowering of consumption but declined to confront the question of government excise and taxes on

---

<sup>14</sup> It has been argued that this shift in emphasis was at least partly due to economic constraints and the need to rationalise health delivery, without disrupting the government’s own fiscal interests in alcohol as a commodity (Petersen 1987).

alcohol and thus (for the time being) avoided dealing with the ‘powerful people and established interests’ referred to by Baume (Lewis 1992a, p. 176,180).

### **5.1. The National Drug Strategy**

The National Campaign against Drug Abuse (NCADA) - now known as the National Drug Strategy (NDS) - was launched in April 1985 by a special Premiers’ Conference on Drugs and provided \$274m in its first six years of operation. It is a cooperative national effort across jurisdictions with the Commonwealth supplying funds on a per capita basis to States and Territories which are matched dollar for dollar. In addition, the Commonwealth provides separate funds for national campaign activities. The Ministerial Council on Drug Strategy was created to provide a coordinated national response to alcohol and other drug matters. The cornerstone of the national policy is the minimisation of harm, which was stated in the first campaign document (National Campaign Against Drug Abuse 1985) and reaffirmed in 1993 (National Drug Strategy Committee 1993). The Committee nominates goals, key result areas, and national policy objectives. In its list of priority program activities the strategy nominates a range of aims including the need to develop public and professional knowledge of intervention and prevention activities such as early intervention, and the need to increase the number of generalist health care workers who directly intervene with patients drinking at harmful or hazardous levels (National Drug Strategy Committee 1993, p.9,11). A sub-committee of NCADA drafted a National Health Policy on Alcohol in Australia, which was released in 1989.<sup>15</sup>

The National Campaign documents do not deal in detail with Aboriginal issues, notwithstanding the fact that WHO had urged attention to ‘populations at special risk’. Indeed, an early evaluation of the campaign, in August 1988, noted that ‘relatively little progress has so far been made under NCADA in (treatment) services for Aboriginal communities ... or for prisoners’ (National Campaign Against Drug Abuse Task Force on Evaluation 1988, p.vii). The evaluation team recommended that Aboriginal people continue to receive special attention in national and cost-

---

<sup>15</sup> The National Health Policy on Alcohol was born of compromise. The final version of the policy was substantially different from earlier drafts, which led to trenchant criticism from some leading alcohol policy researchers who accused the government of ‘watering down’ their recommendations (Elvy 1989; Hawks 1989). Lewis (1992) documents other examples of state interests influencing alcohol policies.

shared NCADA programs - that is, in special services for them and improved access to services provided for the community at large. These recommendations were prompted by a recognition of many of the same problems already noted in the administrative procedures for Aboriginal health generally. For example, the team noted several times in its report that there were disjointed services on Aboriginal drug and alcohol matters at the national Ministerial level, with four separate Ministerial Councils addressing the topic.<sup>16</sup> The evaluation team also drew attention to the problem of Commonwealth-State coordination. The report at 6.4.4. notes,

*We frequently heard Aboriginal people identified as a group who have not yet derived significant benefit from the Campaign ... One major reason for the relatively slow progress made in responding to Aboriginal needs is clearly the fact that relevant funding and policy responsibilities are divided not only between the Commonwealth and the States and Territories, but between Health and Aboriginal Affairs Departments both at a Commonwealth level and within the States and Territories. A number of our informants commented on the need for better consultation between officers of the Commonwealth Department of Aboriginal Affairs and specialists in the drug field.*

*...Effective integration of Commonwealth, State and Territory services for this target group is required, as is a more effective focus of attention within NCADA on developing adequate responses to Aboriginal community needs (National Campaign Against Drug Abuse Task Force on Evaluation 1988, p.150, emphasis added).*

It is important to point out that problems relating to overall policy direction and Commonwealth-State relations mentioned by the strategy evaluation team with respect to the administration of Aboriginal issues, are also apparent in the drug and alcohol area as a whole. For example, just as some States have been recalcitrant in implementing overall principles such as self determination in indigenous affairs, States maintain their right to follow their own programs of action on alcohol

---

<sup>16</sup> There was also confusion within NCADA itself. While NCADA helped to fund (and later coordinated the distribution of) notable Aboriginal anti-alcohol products such as the cassette of songs *Woma Wanti*, and the posters devised by Frape and others (Frape et al 1988) petrol sniffing was not officially part of the NCADA brief. Because it was primarily an 'Aboriginal specific' drug use it was seen to be the responsibility of the Aboriginal Affairs portfolio.

and other drugs. In 1994 it was reported that there were twenty different versions of advice on how to cut down consumption and multiple views on the best type of advertising campaign. Funds allocated to the National Drug Strategy were spent on trying to get State and Commonwealth governments to agree on the same strategy.<sup>17</sup> The Alcohol and Other Drugs Council (a peak non-government drug and alcohol organisation) made a submission to a Public Accounts Inquiry in 1994 which raised concerns both relevant and familiar to commentators on Aboriginal health. The Council's concerns included the lack of inter-sectoral collaboration, the lack of consistent national direction in relation to alcohol and drug policies and practices, and the exclusion of non-government agencies from decision-making<sup>18</sup>.

A largely unaddressed tension existed throughout the NDS between its guiding policy - harm minimisation - and a large section of Aboriginal opinion in the substance abuse field which is aligned solely to the goal of abstinence (Davis 1998). As a result of the NDS there was a gradual shift in orientation in the approach of many mainstream drug and alcohol service providers and a general shift in the climate of opinion about 'addiction', but Aboriginal service providers remained unconvinced. This difference in philosophy (pursued in more detail in Chapter Four) was remarked upon in an evaluation of ATSIC's substance abuse program, eleven years after the formal adoption of harm minimisation by the Federal government (Office of Evaluation and Audit 1996, p.189):

*The evaluation noted a tension created for many, perhaps the majority, of indigenous treatment providers by a national alcohol policy based solely on the principle of harm minimisation. Alternative views included the beliefs that there was no culturally acceptable level of drinking and that the harm minimisation principle alone did not go far enough in eradicating unacceptable behaviour associated with misuse.*

---

<sup>17</sup> David Crosbie, executive director of the Alcohol and Other Drugs Council, speaking at the Winter School in the Sun, Brisbane and reported in the *Australian* 6 July 1994.

<sup>18</sup> In an attempt to attain more transparency in funding allocations (an issue also familiar in Aboriginal affairs), AODC proposed that the States and Territories be required to *account publicly* for nationally-funded programs and services, and should have to provide details of all organisations receiving funding, the amount, purpose, target group and the degree to which the funding reflects national priorities.

It was intended that the body guiding national Aboriginal programs (which at the time was ATSIC) would seek to bring together 'community aspirations with national alcohol and other drug policy trends' but an evaluation of ATSIC's substance abuse program found no evidence that this had occurred (Office of Evaluation and Audit 1996, p.68). This evaluation also found that in reality at a national level, there were few links between the ATSIC Aboriginal substance abuse program and the NDS, and that the NDS had developed with little incorporation of research on indigenous substance abuse.

## **5.2. National Aboriginal Health Strategy coverage of alcohol**

The National Aboriginal Health Strategy report makes only passing reference to the NDS (then called the National Campaign Against Drug Abuse) (National Aboriginal Health Strategy Working Party 1989, p.192), and makes no suggestions as to how the Campaign could contribute to Aboriginal programs. The NAHS devotes a chapter to alcohol and other substances but there is an underemphasis on alcohol abuse as being a key factor underlying Aboriginal morbidity and mortality. The report provides no specific policy guidance on prevention or intervention strategies, missing an opportunity to highlight the role of health service consultations as important moments of contact between Aboriginal people experiencing early problems with alcohol, and health professionals who could intervene. In view of the increasing interest at this time by the wider drug and alcohol community in the role of doctors as providers of secondary prevention, it is notable that the working party asserted that acceptance of a health message is only possible if the deliverer is an Aboriginal health worker. A non-Aboriginal medical professional, it claims, would not be listened to (National Aboriginal Health Strategy Working Party 1989, p.184). Further, the report provides no clear guidance on the pressing and divisive problems surrounding the definitions of alcoholism, disease and harm minimisation. In fact, the report compounds the confusion apparent among Aboriginal people over understandings of alcohol abuse. The report stresses that alcohol misuse is more a community than an individual problem, and that its amelioration will be associated with the development of a 'safe and sensible' attitude towards its use, but is unclear and contradictory on the matter of alcoholism as an illness, and whether the 'disease' of alcoholism is a useful metaphor in the indigenous context. Initially, the report states unequivocally, 'It is considered that alcohol abuse is not only a disease in itself but it is also a

major contributing factor ...' (p.xxxv) and, 'Non-Aboriginal Australia must realise that alcoholism is an introduced illness caused primarily by political, social, economic and cultural deprivation' (National Aboriginal Health Strategy Working Party 1989, p.192). Later in the report, however, the disease model is described as 'outdated' and 'Western'.<sup>19</sup>

The NAHS authors rejected a policy paper on substance abuse submitted to them by an Aboriginal and Torres Strait Islander Substance Abuse Council, although the paper is included as an appendix. The reasons for its rejection are not known. The policy paper in fact makes some useful suggestions, and gives strong emphasis to the need for liaison and cooperation with State and Commonwealth departments and agencies. It suggests that State drug and alcohol agencies should include indigenous representatives on their boards, people who could be selected by indigenous substance abuse workers (National Aboriginal Health Strategy Working Party 1989, Appendix XI).

## **6. Difficulties in national policy development and Aboriginal input**

In the three policy areas presented above as case studies - health, HIV/AIDS and alcohol - difficulties were experienced in allowing for *Aboriginal* input into national policy, and conversely in allowing for *expert* input into Aboriginal policy. All three national policy areas faced similar problems in their attempts to deal with the indigenous component of the population, and many of these were structural, administrative problems. What national policy-makers encountered were the inadequate *mechanisms* whereby they could 'involve' indigenous Australians in policy making and in turn, make national policy and best practice relevant to and appropriate for, indigenous people.<sup>20</sup> Above all, there was a failure at the national level adequately and professionally to

---

<sup>19</sup> At this time, there were several clear recommendations both within Australia and from WHO about the need to de-emphasise the notion of addiction and terms such as 'alcoholic', favouring instead physical or psychological dependence, hazardous use, problem-related use and dependent use (Brown et al 1986; Richards et al.1989).

<sup>20</sup> The only non-government umbrella Aboriginal organisation with a national brief on health was NAIHO which was formed in 1974. Neither it, nor its successor NACCHO were provided with the resources to allow for the formation of a proper secretariat, staff or newsletter which would allow for the dissemination of relevant information to the Aboriginal community-controlled health sector. As it is, these organisations do not receive the various Public Health Bulletins and other information sheets distributed by the States/Territories to their own clinics and health centres. Recently (1998-1999) NACCHO has been properly funded for the first time, and now has a head office in Canberra and employs a number of policy officers who are posted around the country.

represent Aboriginal health. This was largely due to the fact that at the time of these important shifts in national approaches to health issues, Aboriginal affairs were managed by a different department, under a different Minister and portfolio, to the health matters of all other Australians. They were also subjected to considerable administrative change over the period discussed, that is between 1985 and 1995. It was in this period that these policy documents emerged: the National Campaign Against Drug Abuse in 1985, the HIV/AIDS papers commencing in 1986, Better Health for All Australians in 1988, and the National Health Policy on Alcohol in 1989.

Prior to 1984, Aboriginal health administration in the Commonwealth was shared between the Health portfolio (CDH) and the Aboriginal Affairs portfolio (DAA). The state of Aboriginal health, together with concerns over its management, had led to a Program Effectiveness Review undertaken by the Department of Prime Minister and Cabinet in a Liberal/Coalition government in 1980. The Program Effectiveness Review (PER) presented a damning review of the state of the administration of Aboriginal health. It suggested that state grants be tied in future to specific conditions, and that savings could go directly to Aboriginal-run organisations. The PER noted that there was no longer an Aboriginal in the Aboriginal health branch of the Department of Health and a 'lack of any formal advisory group on Aboriginal health through which Aboriginal input could be channelled' (Department of Prime Minister and Cabinet 1980, p.63). Most significantly of all, the Review urged that the administration of Aboriginal health policies, funds and programs be firmly placed within the Commonwealth Department of Health. It noted the existing difficulties in negotiations with State health authorities as 'these authorities do not fully subscribe to the Commonwealth's Aboriginal affairs policies', and believed that giving the CDH full responsibility over Aboriginal health would bring about greater leverage with the States. The PER was actively suppressed and was never made public, although it was circulated underground, particularly among Aboriginal health activists, who had strongly supported its recommendations<sup>21</sup>. Ignoring this recommendation, the Minister for Aboriginal Affairs (Clyde Holding) in a new Labor government, announced in 1984 that health funding and administration was to be transferred wholly to DAA. Here there was little expertise in public health. A small

---

<sup>21</sup> Jack Waterford, journalist and supporter of Aboriginal medical services, wrote in detail about the PER in the *Canberra Times* ('Tactics of delay hold off change' 25 February 1981:18). Nathan and Japanangka (1983) use it to illustrate the poor performance of the states in assisting in programs of self management and their resistance to Aboriginal-controlled medical services.

specialist unit that had existed in the Department of Health (which included medical practitioners with experience in Aboriginal health), and which was intended to provide professional advice to DAA, contracted and finally closed down in 1988. In 1989, the National Aboriginal Health Strategy report recommended that Aboriginal health remain within the portfolio responsibility of the Minister for Aboriginal Affairs, and recommended new tripartite structures (such as a Council of Aboriginal Health). But in 1990, DAA was disbanded and the Aboriginal and Torres Strait Islander Commission (ATSIC) was formed, which inherited the responsibility for indigenous health at a national level. Extraordinarily, the NAHS report appeared not to have anticipated the substantial changes in consultation mechanisms that the creation of ATSIC would bring - indeed the NAHS report all but ignores the fact that massive changes in the administration of Aboriginal funding were in the air while it was being prepared (Anderson 1994a; Bartlett and Legge 1994). For the time being, Aboriginal health was still within Aboriginal Affairs, not the Health portfolio.

ATSIC does not function like a normal Commonwealth department. While it facilitates the disbursement of Federal monies, and has a bureaucratic arm centred in Canberra and with regional offices, its decision-making powers are vested in an indigenous Board of Commissioners and in regional councils elected from local communities in 36 regions which meet regularly to agree on funding allocations. This has been described as a radical advance in the application of self determination principles (Aboriginal and Torres Strait Islander Commission 1994a, p.29). The regional councils are essentially funding allocation bodies and have little scope for policy development (Anderson and Brady 1995). The Commission places considerable weight on advice from its regional commissioners who include people with no special training or expertise in health service delivery, policy or planning, and it is undoubtedly a difficult task to obtain from such a structure the kind of specific and detailed advice that would be adequate to feed into nation-wide policy documents. The ATSIC Board has a policy of slowly devolving the major part of its funding allocation powers from its Canberra head office to the regional councils, and in 1993-4, the ATSIC act was amended to increase the decision-making powers of regional councils. Competing bids for funding of different programs, including substance abuse programs, were assessed by the elected councillors. The pressures of this arrangement were roundly condemned by the Social Justice Commissioner:

*If the sheer volume of work does not act as a disincentive to effective localised decision-making, the decisions to be taken by Regional Councillors with only very limited resources on the basis of very limited information often place them in impossible positions ... Indigenous peoples are being forced to choose between various alternatives, all of which are their right as citizens of Australia. No other Australians are required to choose between such basic rights as water or primary health care, a road or health education (Dodson 1995, p.120-121).*

In the case of substance abuse the competitive bidding for funds was potentially disastrous. By 1994 there was no specific figure allocated for substance abuse and it was entirely up to the regional councils to decide whether to spend funds on the issue at all. No strategic advice about weighing up competing priorities was channelled to regional councils from head office.<sup>22</sup>

As already mentioned in Chapter One, after intense lobbying (which began in 1993) by Aboriginal health organisations, the Australian Medical Association, the Royal College of General Practitioners and others, ATSIC was relieved of its role in managing health funding in July 1995, having held it for five years. What is significant about the content of the lobbying arguments put forward by these organisations in 1993 and 1994 is that they stressed the need for professionalism and health expertise, which were perceived to be lacking within ATSIC.<sup>23</sup> Another factor in the arguments for the transfer to CDH was to obtain equitable access to national

---

<sup>22</sup> Prior to this date, funds for substance abuse programs were earmarked as such. However, in keeping with the ongoing decentralisation after 1993-4 all funds previously allocated for substance abuse (approximately \$13m per annum) were pooled for regional councils to allocate in whichever way they determined. This meant that substance abuse programs had to compete with bids from all other programs and were subject to intense local politicking over allocations. Further, this decision meant that the large extra allocations for substance abuse (\$61.6m over five years) which followed the Royal Commission into Aboriginal Deaths in Custody could not be monitored to see whether these funds were in fact expended on substance abuse programs (Office of Evaluation and Audit 1996; Smith 1993). This disturbing fact passed almost entirely unremarked.

<sup>23</sup> The AMA felt that although ATSIC was doing its best, there needed to be more health expertise; NACCHO expressed the view that transfer to the CDH would offer better specialist support as well as Ministerial attention; and the evaluation report of the NAHS noted that the capacities of ATSIC and the short-lived Council for Aboriginal Health were weakened by a lack of expertise in health systems, planning and policy development (Gordon 1994; Kunitz and Brady 1995). As noted in Kunitz and Brady (1995), there had been calls since at least 1979 for greater professional and technical oversight of Aboriginal health at a national level. It must be said, though, that there were political undertones to the debate: the relationship between the Aboriginal health movement and ATSIC was often acrimonious. The health services resented having their funding at the mercy of the local politics inherent within the regional council structures of ATSIC.

resources allocated for health. The decision was taken to transfer Aboriginal and Torres Strait Islander health to the Commonwealth health portfolio including funds of \$111.6m. The greatest portion (\$92m) was earmarked for the 159 Aboriginal and Torres Strait Islander health services which are funded directly (Gordon 1994; Griew 1996; Kunitz and Brady 1995). ATSIC strenuously resisted the move, and at the regional level, opinion was split between those Aboriginal people whose positions and status were reliant on ATSIC, and others, particularly those associated with the community-controlled health services. The Memorandum of Understanding signed on 13 November 1995 by the Chairperson of ATSIC and the Minister for Health stated (at 3.2.1.) that the Minister 'will be responsible for decisions regarding the allocation of funding for primary health care and substance abuse services following the transfer, after taking into account advice from ATSIC Commissioners and Regional Councils'. It was hoped by all involved that this move would help to diminish the 'tangled bureaucratic maze' which prevented proper planning and delivery of Aboriginal health services (Bartlett and Legge 1994).

In view of these constantly changing administrative circumstances surrounding the provision of Commonwealth funds and Commonwealth policy advice in Aboriginal health matters, it is not surprising that a competent and consistent indigenous input into national policy documents was lacking. I discussed earlier some of the inadequacies of the National Aboriginal Health Strategy. These inadequacies in prioritisation and strategic planning by the NAHS, together with the background of administrative chaos described above, further contributed to ongoing problems for policy-makers. As mentioned, Australia's national goals and targets in health were first discussed in 1988. An interim set of Aboriginal health goals and targets was prepared in 1991, but attempts to finalise them encountered wrangling between the Aboriginal health services, the States, and an ATSIC-established Council for Aboriginal Health. NACCHO refused to endorse them.<sup>24</sup> Since then, the States and Territories have been developing their own goals and targets, independently of the Commonwealth - precisely what the national Aboriginal health 'policy' was originally

---

<sup>24</sup> Seven hundred copies of the draft were distributed for comment; 27 responses were received and the draft then became subject to disagreement between the States/Territories, and the numerous representative and consultative bodies that were in the arena at the time (Anderson and Brady 1995).

designed to prevent.<sup>25</sup> The national policy-makers were forced to press on. In the 1993 revised Commonwealth report on national goals and targets for Australia's health, Aborigines are included as one of the 'priority populations' in relation to several specific targets such as reducing interpersonal violence, injury, and hazardous alcohol consumption (Nutbeam et al. 1993).

With respect to drug and alcohol issues, the difficulties experienced by the NDS in focussing on Aboriginal drug and alcohol problems as a 'population at special risk' were also partly associated with the turbulent state of Aboriginal substance abuse funding and administration at the level of the Federal government between 1985 and 1995. At the time when the National Campaign began (1985) responsibility for Aboriginal substance abuse had just been transferred to DAA (the Aboriginal affairs portfolio), which maintained a small substance abuse branch within its health section. When ATSIC was established in 1990 it inherited the national responsibility for substance abuse program funding, although funding for special projects and educational strategies for indigenous people were *also* obtainable from the Commonwealth's Drugs of Dependence Branch. Staffers in the regional offices of the bureaucratic arm of ATSIC had limited expertise in substance abuse. The growing autonomy and discretion at the level of the ATSIC regional councils and the subsequent gradual decline in the powers of central office to offer overall direction and policy advice, compounded the existing inadequacies in expert policy advice on drug and alcohol issues.<sup>26</sup>

At times, ATSIC itself claimed that it was not being consulted on particular national health issues. For example Peter Shergold, the CEO of ATSIC reported to the Access and Equity enquiry (House of Representatives Standing Committee on Aboriginal Affairs 1993, p.108) that a policy was prepared on tobacco consumption.

*We were not consulted. The rate of smoking is, I think, 33 or 34 percent in the total*

---

<sup>25</sup> A useful annotated bibliography by Neil Thomson and Patricia Merrifield in 1988 lists some of these State policy initiatives (Thomson and Merrifield 1988).

<sup>26</sup> Many of the coordination tasks of the central office were also curtailed by the establishment of an ill-fated Task Force on Substance Abuse in 1992 which failed to fulfil its terms of reference and was later disbanded. The Task Force was also intended to have a role in monitoring how the ATSIC program fitted into the national substance abuse effort (Office of Evaluation and Audit 1996). This it obviously failed to do.

*Australian community; amongst Aboriginal people it is somewhere between 74 and 75 percent. It is clearly something that is of crucial interest to Aboriginal and Torres Strait Islander people. Yet nobody thought 'We are preparing a policy on tobacco consumption, does it have a particular relevance to Aboriginal people?' My dealings with Secretaries at the head office level involve trying to overcome that problem.*

The Access and Equity report observes that it should be automatic for indigenous people to be involved in the development of any new initiative that affects them, not merely added in as an afterthought. It is clearly no longer acceptable for national policies merely to note that indigenous people are special priority populations, and require culturally appropriate and community-based approaches. Nevertheless it is also clear that on many occasions, national policy developers tried and failed to obtain any directives or input from Aboriginal representative bodies.<sup>27</sup> For example the National Drug Strategy undertook a major evidence-based review of 'ideal' treatments for alcohol problems, the Quality Assurance Project.<sup>28</sup> The Project reviewed the treatment processes for the management of alcohol dependence which were best supported by the available evidence and by expert consensus. In view of the urgent need for specialist input into the increasingly fossilised and polarised arena of treatment for Aboriginal alcohol problems, it was an important opportunity. In fact, the Quality Assurance Project devoted only one paragraph to Aboriginal and Torres Strait Islander people (Mattick and Jarvis 1993, p.222). Its authors had tried in vain to obtain input on Aboriginal issues from several different indigenous and government agencies including ATSIC, and each had referred the issue to another.<sup>29</sup>

The indifference which was displayed at a policy level - brought about by what can be described as the paralysis of cultural relativism - together with the absence of any clear directives from

<sup>27</sup> It is not just non-Aboriginal government bureaucrats who have had difficulty in eliciting Aboriginal advice. Even when a wholly Aboriginal representative body seeks input from Aboriginal communities and organisations, the results can be disappointing. For example, the NAHS working party sought submissions for its enquiry but received very few formal submissions. Those they did receive were more oriented to 'philosophical, political and public health issues' than to specific disease problems. The Working Party thought this was partly because organisations 'see submissions as the means for seeking funding rather than a vehicle for expressing concern or need' (National Aboriginal Health Strategy Working Party 1989):appendix I).

<sup>28</sup> The Project was hailed as an excellent example of research which both assesses the effectiveness of policy and guides future policy (Kingdon 1993).

<sup>29</sup> Richard Mattick, National Drug and Alcohol Research Centre, pers.comm.

Aboriginal agencies and organisations, was particularly serious in view of the existing awareness of the disastrous consequences of alcohol abuse. Survey data show that approximately 62 percent of indigenous people consume alcohol, 22 percent are ex-drinkers, and 15 percent have never been drinkers (Commonwealth Department of Human Services and Health 1994; Hunter 1992; Hunter, Hall, and Spargo 1991). Of those people who do drink, about two-thirds report harmful levels of consumption (Hunter, Hall, and Spargo 1991; Perkins et al. 1994; Saggers and Gray 1998). The quantities associated with these 'harmful' levels are enormous. Hunter and colleagues report that average consumption among Kimberley Aborigines on drinking days was between 15 and 17 standard drinks (Hunter, Hall, and Spargo 1991). In Queensland, almost two-thirds of Aboriginal men are engaged in heavy regular, very heavy regular, or binge drinking in five communities (Martin 1993; Martin 1998). Martin calculated consumption levels for Cape York Aborigines to be between 25 and 30 litres of pure alcohol per year, some of the highest intake measured anywhere in Australia (Martin 1998).<sup>30</sup> Bingeing is the major distinguishing feature of Aboriginal drinking styles in both remote and rural regions. A survey of New South Wales country towns found that the majority of drinkers who had recently consumed were binge drinkers. An Adelaide survey of urban health service clients reported that 53 percent of males and 17 percent of females had 'heavy daily use' or 'binge drinking' (Lake 1989; Perkins et al. 1994). Two Sydney surveys report that between 29 and 44 percent of drinkers consumed more than seven drinks per session (Aboriginal Medical Service 1991; Tharawal Aboriginal Corporation 1994). A minority of indigenous drinkers are reported to be engaged in moderate intake (Lake 1989; Perkins et al. 1994). Alcohol is implicated as a direct cause of approximately 10 percent of deaths among Aboriginal people, which is three to five times higher than among the general Australian population.

## Conclusion

It has to be said that the government bodies concerned with the formulation of national policies on different health issues have a difficult time ascertaining the most appropriate approach to their Aboriginal constituents. In the 1960s and 1970s policy and planning documents could deal with the Aboriginal component by ignoring it entirely, or relying on the advice of departmental

<sup>30</sup> Using NHMRC categories of responsible, hazardous and harmful drinking and converting their figures given in grams per week of pure alcohol, harmful drinking for males is defined as anything over 21.8 litres of pure alcohol per year (Martin 1998:6).

staffers. However, the increasing strength of the Aboriginal health movement, as well as a groundswell of change internationally in attitudes towards indigenous 'fourth-world' populations - have all contributed to government agencies becoming sensitised to the need for consultation, community involvement, and (increasingly) separate treatment. In this new sensitised atmosphere, government departments have become cautious in their dealings with Aboriginal issues. They have prevaricated over where and how Aboriginal affairs - such as health - should be administered. They are increasingly unwilling to make definitive statements in policy documents, or to provide advice, unless these have been referred to Aboriginal organisations. The chaotic administrative circumstances surrounding Aboriginal health and substance abuse have undoubtedly contributed to the lack of detailed input into national policies that I have described. These include the lack of any long-lasting national policy body which could have brought together Aboriginal and non-Aboriginal expertise to give advice on a range of health issues affecting indigenous people.

It could be argued that this trend - of sensitivity within the bureaucracy and separatism on the part of the Aboriginal health movement - is entirely justified and necessary in view of the past gross neglect on the part of governments, the earlier absence of Aboriginal voices being heard by government program managers, and inept medical encounters. However there is a danger that this extreme sensitivity can result in the marginalisation of Aboriginal issues from a full, thorough and expert assessment in national documents and a strangulation of action. With an uncertain line of communication between health and Aboriginal affairs agencies and difficulties in obtaining clear directives from Aboriginal representative groups, as described in this chapter, it is hardly surprising that national policies sometimes fail to represent any substantial Aboriginal perspective at all. Each of the major government reports to which I refer assigns Aboriginal and Torres Strait Islander people a few paragraphs and these inevitably allude to the *difference* between indigenous and other Australians. A recent commentator has suggested that the idea of difference, which is entirely the product of culture, is akin to the re-emergence of the Romantic doctrine of innate racial character (Kohn 1996, p.278):

*In the world of absolutist relativism, all knowledge is subjective and specific to groups. African and European Americans live in different cognitive worlds; so do women and*

*men. These worlds are radically incompatible, and so there is no point in trying to communicate between them. ‘Difference ... has been resolved into indifference, an unwillingness to engage with what anyone else has to say...’*

In Chapter Four, I turn to an analysis of Aboriginal and other understandings of indigenous drinking problems and how these were increasingly informed by notions of difference. I re-introduce the influence of the international arena, in particular the influence of North American First Nations consultants on Aboriginal alcohol programs.

## CHAPTER FOUR

---

### Constructions of Aboriginal Alcohol Use

*By the 1980s national policies in health had given only cursory consideration to indigenous Australians. A consequence of the gulf which developed between policy and planning for the wider population, and that for indigenous people, was that certain areas of Aboriginal health were in effect cut adrift, and proceeded to develop independently. One of these was substance abuse. This chapter begins by analysing earlier perceptions of Aboriginal alcohol use as typified by submissions to a 1976-1977 House of Representatives enquiry into Aboriginal alcohol problems. These are important because they reveal polarised positions and a lack of consensus on interventions. One outcome of the enquiry was the continued emphasis on late-stage residential treatment for those with alcohol problems. These programs were not only unattached to mainstream drug and alcohol agencies, they were unattached to the community-controlled health services. This allowed them to become insulated from developments taking place elsewhere in Australia which began to change thinking about addiction. Following this, I describe how the Aboriginal alcohol discourse shifted to notions of cultural loss, and a renewed emphasis on indigenous solutions to alcohol problems. In time, this led to the involvement of North American indigenous alcohol advisors in Aboriginal programs, an involvement which reinforced the separation of community-controlled programs from wider developments taking place at home, in Australia.*

#### 1. Historical antecedents influencing Aboriginal perspectives on alcohol use

In response to the alcohol abuse of their own people, Aboriginal commentators have had to confront an ideological dilemma associated with the history of prohibition. The prohibitions on Aboriginal drinking were discriminatory and unworkable, and the right to drink was an important segment of the gradual dismemberment of a raft of racially

discriminating legislation. Government policy had shifted from ‘protection’ to ‘assimilation’ by 1939, carrying with it ideas of equality and the aim of gradually removing protective laws. The loosening of legal restrictions meant, in effect, that the patterns of consumption which had been established under conditions of restrictive surveillance became officially endorsed, or at least were ‘allowed’. It became clear that most of those people who drank were doing so detrimentally, to themselves and others. This excess was also associated with factors coincidental to the end of prohibition such as the downturn in employment for rural Aborigines (Beckett 1984; Hunter 1993). Whatever the enabling factors, Aboriginal drinkers consumed punishing amounts of alcohol. People were soon being prosecuted in large numbers for alcohol-related offences, and from the 1960s onwards, charges associated with alcohol use have accounted for the majority of convictions of Aborigines in all States (Sansom 1980). Despite this patently damaging and widespread pattern of excess, the emotional and political baggage of prohibition now still makes it very difficult for Aboriginal spokespeople to advocate restrictions on supply which could in any way be likened to ‘prohibition’. This is the ideological dilemma.

The right to drink has long been complicated by a number of attributions, and these explain why it is that drinking alcohol holds such a powerful symbolic link for Aboriginal people with the principles of equality and citizenship. Contrary to conventional wisdom, the right to drink was not granted in the 1967 Referendum, as is often stated. The Referendum merely enabled Aborigines to be counted in the census, and gave the Commonwealth concurrent powers with the States to pass laws regarding Aborigines (Attwood and Markus 1997; Brady 1991). The laws of the States or Territories - not the Commonwealth - allowed or disallowed Aboriginal people to have legal access to alcohol.<sup>1</sup> By the 1960s several States had repealed earlier restrictions on alcohol, although there were still ‘special measures’ for Aborigines, which the government argued were ‘to protect them against undesirable influences of modern society’ (e.g. restrictions on the sale of liquor) (Department of External Affairs 1964). In South Australia for example, some Aborigines could drink in 1962 unless they lived in ‘primitive

<sup>1</sup> It is ironic that Australian authorities in New Guinea repealed prohibition for ‘natives’ there in 1962, while several States at home did not repeal these laws for Aboriginal people until a few years later. In the US, Federal Indian prohibition was repealed in 1953.

conditions'. Several States had legislation that allowed alcohol to be purchased and consumed by Aboriginal people of mixed descent and others who could establish that they complied with certain standards of hygiene, intellect and good (ie non-Aboriginal) company. For the purposes of this legislation, such a person was exempted from being treated as an Aboriginal. Under a Western Australian Act of 1944 Aborigines could apply for 'citizenship' if they conformed to these rules. Citizenship of this sort bestowed the right to drink, but could be withdrawn following two convictions for an offence, including habitual drunkenness. This constituted an early association in the minds of Aboriginal people between the notion of 'citizenship' and the right to drink. The Northern Territory had a similar list of 'exempted' Aborigines who could legally consume alcohol.<sup>2</sup>

Aboriginal people across the country interpreted the right (but not the obligation) to vote in Federal elections granted in 1962, as also giving them 'citizenship', and thus the right to drink alcohol legally. Sansom, working in the Northern Territory, noted that in the interim period between voting rights in 1962 and the eventual end of prohibition in 1964, Aboriginal people began to drink openly (Sansom 1980). After repeal, restrictions did continue on some mission and other settlements, and in country towns particularly, licensed outlets still imposed their own versions of the colour-bar (using dress requirements to exclude Aborigines). However, by and large there was unfettered access to alcohol, other than those restrictions which occurred by default as a result of distance and geography. To compound the confused attributions of citizenship and drinking rights even further, many Aboriginal *and* non-Aboriginal commentators both at the time and since, believe that the 1967 Referendum bestowed drinking rights upon Aboriginal people<sup>3</sup>. Interviews with Aboriginal people who remember the period reveal

---

<sup>2</sup> Aboriginal people dealt with these humiliations in part by means of sardonic humour: the list of Aboriginal wards in the NT was known at the time and since as the 'stud book'. The certificate of citizenship issued in WA was referred to as the 'dog tag'.

<sup>3</sup> Aboriginal people remembering the Referendum made comments such as: 'In 1967 the Referendum meant that we had citizenship rights, voting rights and the right to enter a hotel and have a beer. It was also the recognition of Aboriginal people as Australians' (Bill Humes); 'The hotels were full of our people. The thing I remember about the Referendum is that Nyungahs celebrated going into hotels to have a drink, and for the first time they felt happy the alcohol drowned the frustrations that were kept since white invaders. The sad thing was, they kept it up and they turned into compulsive drinkers' (Leisha May Eatts) (cited in Attwood and Marcus 1997:144,138).

interpretations such as this:

*I didn't involve (with alcohol) when I bin a young one because it wasn't agreement for Aboriginal people to go into a pub and when I bin thirty years of age and people said we legal to go into a pub like a European and drink. Yes, citizenship came in and that's the reason I had to go and drink. Yeah, I had to go and drink because I thought that I'm a hard-working man and I legal to have a few beer and go home ... (Brady 1995a, p.111)*

There is no doubt that the term 'citizenship' has become a polysemic term, bearing with it a host of meanings associated with equality, an end to discriminatory legislation, and the right to go where white people go and do as they do - which included drinking alcohol. Beckett (Beckett 1984) argued that by defying official prohibition, the Aboriginal people with whom he worked in New South Wales in the 1950s were conducting a form of pre-political resistance. In 1960 T.G.H. Strehlow stated that for most Aborigines, liquor had become the 'symbol of emancipation, of equality with the white man, and of full Australian citizenship' (Duguid 1978, p.188). By definition, drinking alcohol became inextricably associated with equality and status, as it has for many other minority and indigenous groups,<sup>4</sup> and indeed for mainstream populations subject to prohibition.

During the years of prohibition in the United States, drinking came to hold the allure of a self-righteous pleasure: 'Drinking, we proved to ourselves our freedom as individuals and flouted Congress' (Room 1984b, p.173). The fact that discriminatory laws existed for so long in Australia, and in such a complex variety of forms within the quite recent remembered past, meant that the right to drink has an enduringly high premium among Aboriginal people. This at times has provoked an exaggerated antipathy to any suggestion of restriction. While in Central and Northern Australia, numerous Aboriginal communities remained dry as a result of local Aboriginal decision-making or the remaining influence of the church, urban activists saw any restriction on Aboriginal

---

<sup>4</sup> Bain suggested that the people with whom she worked interpreted the new equality as *requiring expression* through the act of drinking (Bain 1974). Heath, and contributors to Marshall (Heath 1987; Marshall 1982) observe that drinking alcohol constitutes a marker of equality for many minority and indigenous groups.

access to alcohol as being politically unacceptable<sup>5</sup>. It must be said, however, that this antipathy has a parallel in broader Australian community attitudes. There has long been an ideological war in Australia between so-called ‘wowsers’<sup>6</sup> and libertarians, which has made it easy to link anything smacking of restriction with wowserism. As Robin Room has pointed out, not only were post-war Australians anti-puritanical about alcohol, they were concerned lest anyone should even *think* of them as wowsers. This, he continues, imposes ‘an effective block on saying anything negative about alcohol or its availability’, and constitutes a form of self-censorship (1985b, p.179).

## 2. The problematisation of Aboriginal alcohol use

By the 1970s Aboriginal people were beginning to experience the full impact of the high levels of alcohol consumption that had begun fifteen to twenty years earlier (Beckett 1984; Hunter 1993). Indeed, alcohol consumption had increased in Australia as a whole between 1966 and 1976 (Drew 1977) and throughout most of the world there had been a general rise in levels of alcohol consumption through the 1960s and early 1970s (with a concomitant increase in alcohol-related health and social problems) (Archibald 1985).<sup>7</sup> In 1973 a Board of Inquiry in the Northern Territory, charged with examining all aspects of the sale and consumption of liquor, reported widespread concern in Aboriginal communities at the prospect of unlimited amounts of liquor being brought into communities (d'Abbs 1995). In 1974 a planned workshop on Aboriginal mental and social health, funded by the Federal government, was redesignated (largely by Aboriginal representatives) to become the first national conference on Aboriginals and Alcohol. When it eventually took place at Macquarie University in May 1976, the conference was addressed by a high-profile politician, the Minister for Aboriginal Affairs, Mr Ian Viner.

---

<sup>5</sup> Bob Liddle, President of Congress in Alice Springs, told the House of Representatives Standing Committee in 1976 that he would *personally* be in favour of restrictions for Aborigines but that it would be ‘going back to prohibition days’ and would therefore not be realistic (HRSCAA 1976:1215)

<sup>6</sup> Australian slang for a puritanical fanatic.

<sup>7</sup> The 32nd World Health Assembly in 1979 declared that alcohol was one of the world’s major public health problems, and urged member states to take action to reduce consumption (Archibald 1985).

By 1976 the relationship of Aboriginal people to alcohol had become problematised to the extent that the House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) established a subcommittee to examine Alcohol Problems of Aboriginals. The Committee was chaired by Phillip Ruddock, and toured the country in 1976 and 1977 holding public hearings at which members were presented with Aboriginal and interested non-Aboriginal submissions. None of the committee members had expertise in health or addictions. The Hansard reports of the Standing Committee (referenced hereafter by the initials HRSCAA) reveal much of the thinking of the time about alcohol problems in general as well as those experienced by Aboriginal people. It took place at a time when Aboriginal positioning on alcohol problems was beginning to crystallise, when Federal monies were being channelled into specifically Aboriginal programs, and also at a time when major shifts in domestic and international policy were beginning to occur. For these reasons it is pertinent to examine it more closely.

The Standing Committee received a welter of submissions, opinion, advice and polemic. Three major overlapping, and not mutually exclusive themes emerged:

- A ‘wet’, laissez-faire position on alcohol, urging availability under Aboriginal control, with both proponent and dissenting views;
- A ‘dry’ position, favouring strict controls, abstinence and AA-style approaches. These were also disputed.
- A separatist position, based on the assumption that Aboriginal people (rather than white Australian professionals) knew best how to deal with alcohol problems. This was a variant of the dry arguments.

## **2.1. The wet position**

A laissez-faire and generally ‘wet’ perspective on access to alcohol was discernable in many of the submissions put to the HRSCAA. To some extent these mirrored Australian government and public opinion of the era on alcohol in general (the ‘wet generation’ idea proposed by Room) (1984b). They also reflected 1970s Aboriginal affairs policies of self

determination and self management and associated ideals of choice and local decision-making. Resolutions from the first major national conference on Aborigines and alcohol (held in Sydney) included one which recommended local availability in 'tribal' communities, and criticised discriminatory practices in Aboriginal communities (such as having permits to drink).

Many submissions to the HRSCAA promoted the view that choice was a key issue, and that Aboriginal people would come to terms with alcohol if they were allowed to control consumption at on-site canteens. It was proposed that if local Aboriginal organisations in discrete communities, such as community councils, had control over the 'rationing' of alcohol, then moderate drinking would automatically develop (HRSCAA 1976-1977, p.422). There was harm minimisation talk (although these words were not used then) about providing low-alcohol beer, and smaller cans (HRSCAA 1976-1977, p.612). Aboriginal women said that if there were canteens on the communities, their men would stay at home (HRSCAA 1976-1977, p.669). Ella Stack (then Mayor of Darwin, later Secretary for Health) thought onsite canteens a good idea. The Director of Health in the NT Charles Gurd, stressed the need for people to have choices in their mode of consumption, such as family centres, canteens, clubs and restaurants; he thought that the differences between the races had been exaggerated (HRSCAA 1976-1977, p.283). He thought liquor facilities in communities should be under the control of the 'Aboriginal community authority'. A medical practitioner who had worked at Yirrkala, Northern Territory suggested 'equalising' Aboriginal access to alcohol in clubs and hotels, having tribal bars named after the 'tribes' concerned, and even proposed the establishment of an Aboriginal brewery in Arnhem Land.<sup>8</sup> The submission from Congress (the Aboriginal controlled health service in Alice Springs) stated that 'prohibition' appeared to be unworkable under the present social structure (HRSCAA 1976-1977, p.1194), but was guarded about canteens, saying that on-site canteens required a great deal of discussion and consultation. Congress did, however, suggest that there was a need for a licensed

---

<sup>8</sup> Dr Tom Gavranic thought this would help communities to become financially self-sufficient and that the beer be called 'Arnhem Lager' or 'Brrang Brrang Beer' (HRSCAA:2296). The latter name presumably refers to a location in the region named Birany Birany.

social club for Aborigines in Alice Springs where people could relate to alcohol in a more positive, socially cohesive way.<sup>9</sup> Overall, Congress supported a ‘wet’ position.

There were dissenting voices however. Harry Giese from the Northern Territory reported that he had started social clubs but they ‘simply became grog sessions and nothing else’ (HRSCAA 1976-1977, p.828). There were other warnings - the Walkabout Hotel in Nhulunbuy (an unwanted licence brought about as the result of development of the Nabalco Bauxite mine there) had a list of people signed by their relatives to whom alcohol was *not* to be sold.<sup>10</sup> Evidence was provided that community-operated canteens were subject to random changes in availability: for example the Aboriginal-run licensed club at Snake Bay had started with a two-can a day limit and moved rapidly to 24 cans a day. On Palm Island, where a canteen had opened in 1973, evidence was presented that 85% of adults there were ‘drunk every day of their lives’. The canteen was said to have no restrictions, no toilets, no food, and no entertainment (HRSCAA 1976-1977, p.2944). Croker Island, Elcho Island, Milingimbi, Goulburn Island and Yirrkala were all opposed to the sale of alcohol. Some of the first formal Aboriginal objections to liquor licences were being made at this time.

In retrospect, it is possible to suggest reasons for this enthusiasm for on-site liquor outlets and ‘controlled’ drinking - notwithstanding the dissenting voices noted above. One possibility is that the extent of problems associated with heavy consumption and difficulties (either real or incipient) in controlling it may have been downplayed. In the case of presentations to the HRSCAA, proponents of a ‘wet’ position may have defused rumblings of concern for any number of reasons: as a result of their optimism about self determination; hopes for the potential in local decision-making and Aboriginal control; and the belief that these factors would bring about sociable drinking. DAA in particular

---

<sup>9</sup> Seventeen years later this ‘social club’ finally became a reality in Alice Springs, when the Aboriginal-owned and run Tyeweretye Club opened in March 1993.

<sup>10</sup> A Church report in 1974 quoted an East Arnhemland spokesman as saying ‘[the government] turn around and say there are pubs everywhere all over the world so why shouldn’t there be one here - even though everyone knows the result. The law coming from the Government is bad and good; we tell them to take the Walkabout from Nhulunbuy and send it back to Sydney or Melbourne and build it there; they said to me that it is too hard to send it back as there are millions and millions of dollars spent on it.’ (United Church in North Australia 1974)

was acutely conscious of the danger of ‘imposing solutions’ onto Aboriginal populations at a time when government policy was attempting (in principle at least) to return the initiative to them. There seems also to have been a degree of ignorance about the limited extent to which Aboriginal people in remote tradition-oriented communities could enforce any secular authority over their fellow-residents on matters of social control. In addition, there was a reaction against earlier discriminatory or racist positions on Aboriginal drinking, and increasing outrage over incidents in which Aborigines were refused service in clubs and pubs. Now Aboriginal drinking problems were said to be ‘no worse’ than those of other Australians, just more visible (HRSCAA 1976-1977, p.149).

This tendency to deflate problems associated with alcohol use was also apparent within the social sciences. In 1984 Robin Room published an article which analysed this inclination. He suggested that there were methodological and theoretical characteristics within anthropology (such as functionalism) which were inherently problem-deflating. He proposed that many social researchers were themselves from the ‘wet generation’, and held liberal attitudes (Room 1984b). His publication prompted on-going debate and some soul-searching among researchers, including the Australian anthropologist Jeremy Beckett who wrote of his own previously nonchalant approach to Aboriginal heavy drinking in rural New South Wales, and American anthropologist Mac Marshall who had written an ethnography of alcohol use in Truk, Micronesia (Marshall 1979). Both have since admitted that they underplayed the extent of the alcohol-related problems they saw. The prevalence of the disease model of alcoholism also had an underlying role in this diminution of the extent of alcohol problems. By applying the narrow ‘stencil’ of what constituted ‘real’ alcoholism (and finding that it did not fit everyone), researchers and lay commentators alike were able to ignore the multitude of alcohol-related problems that were actually present (Beckett 1984; Marshall 1990).

## **2.2. The dry position**

In opposition to the view that Aborigines would ‘learn’ moderation, the Standing Committee heard persuasive evidence to the contrary - that social drinking was not

possible for Aborigines, total abstinence was the only way to manage Aboriginal drinking problems, and that this was best achieved by means of Aboriginal-run residential programs. Few non-Aborigines promulgated a 'dry' position, or made suggestions for versions of prohibition. Dr Randy Spargo from WA was one of these few; he proposed that individual Aborigines should drink only if licensed to do so. He was sure that Aborigines were going to be wiped out by alcohol and venereal disease (HRSCAA 1976-1977, p.1538).

The dry position was promulgated to the Committee by some influential and forceful Aboriginal alcohol spokespeople. At the time, there were comparatively few Aboriginal people engaged in the drug and alcohol area, and virtually all of these spokespeople were wedded to the dry position, and more precisely, to the use of the AA model. Foremost among them was Val Bryant, an Aboriginal ex-drinker and long-term AA member. She had joined AA in 1963 and 'hasn't had a drink since'.<sup>11</sup> At the time of the Standing Committee, the most well-known (and well publicised) Aboriginal program in the country was Benelong's Haven<sup>12</sup> which Val Bryant had established in 1974. This was the name given to two residential 'half way' houses in Sydney; the regime was based firmly on AA.<sup>13</sup> Bryant claimed AA was highly suitable for Aborigines, and residents of the program toured the AA meetings of Sydney several evenings each week. In the early years, Benelong's houses were known as half way houses rather than 'rehabilitation' centres, and their activities were described as being a 'unique blend of AA and Aboriginal spirituality' (Carroll and Wilson 1984). The reasons claimed for Benelong's 'success' were said to be: that Aboriginal alcoholics are best understood by Aboriginal alcoholics; that the spirituality of the AA program suits many Aborigines; and that the

<sup>11</sup> Quoted in *Aboriginal News* 1978, p.16

<sup>12</sup> Benelong's Haven was named after Bennelong [sic] an Aboriginal man captured by the British in 1789 (a year after settlement) and brought to Sydney Cove where he lodged with Governor Phillip. He sailed to England in 1792 and was presented to King George III, but on his return was said to no longer fit either in his own society or that of the white man. He became rather fond of alcohol; he would 'drink the strongest liquors, not simply without reluctance but with eager marks of delight and enjoyment' (Flannery 1996)p117. He learned to raise his glass and give a toast to 'The King'. Val Bryant, the founder of Benelong's Haven, observed that he had thought that *wine* was the king: 'Benelong stated the situation exactly, for the flagon is the king of the Aboriginal people and this is the problem' (HRSCAA:3046) Bennelong died in 1813.

<sup>13</sup> The first Alcoholics Anonymous branch in Australia was formed in 1945, and there was an explosive growth of the organisation in the 1950s (Room 1985b).

hostel concept provides Aboriginal alcoholics a refuge, protecting them from pressures to drink (HRSCAA 1976-1977, p.2600). Val Bryant and her colleague Jim Carroll travelled Aboriginal settlements in Queensland and New South Wales proselytizing for Benelong's and holding AA meetings. Each member of the HRSCAA visited Benelong's Haven. Numerous submission to the HRSCAA praised Benelong's, spoke of its apparent success rate<sup>14</sup> and hoped that it would become a blueprint for efforts in other parts of the country. Indeed at the time of the Standing Committee Benelong's had already spawned several offshoots such as MASH (Moree Aboriginal Sobriety House) in Moree; Rose Colless was planning another in Queensland. Benelong's staff helped to establish FORWAARD in Darwin in 1976, which in turn influenced the formation of a similar alcohol facility on Palm Island in Queensland. In this way the 12 step model was disseminated to Aboriginal people across broad regions of the country. Even in the 1990s its clientele is drawn from as far afield as Tennant Creek in the Northern Territory.

Harold Hunt was another influential 'dry'. He was employed as an alcohol counsellor by the NSW health commission, having given up drinking in 1968. He firmly believed that 'upstream' programs were needed, not just end-stage half way houses, and that Aboriginal counsellors needed to be recovered alcoholics but that they also required training. Hunt promulgated the use of AA for the drinker, Al-Ateen for children and Al-Anon for spouses and close family members, and urged that like the diabetic who requires regular insulin, the alcoholic requires regular, continuous treatment. Evidently aware of the critics of the disease model, Hunt wrote in the Aboriginal Health Worker (Hunt 1984, p.12)

*For those who refuse, or are unable to accept alcoholism as a disease, let's see what the Universal English Dictionary describes as disease ... 'Any state of a living body in which the natural functions are disturbed'. A full and complete description of alcoholism, no question.*

---

<sup>14</sup> There were several different figures presented to prove Benelong's success rate. One was that 35% of residents were sober after three months (p.72); another that 80% of those completing the program were sober (p.3085), but only one quarter of those admitted stay for the full three months (p.3155).

His submission to the HRSCAAA began:

*The disease of alcoholism being the most insidious mental, moral, spiritual, social and physical destructive element in the lives of Aboriginal people, needs to be dealt with on just as large a scale as its destructive nature (HRSCAA 1976-1977, p.2711)*

Other prominent people included Cliff Fua, who was based in Queensland. He helped establish an influential drug and alcohol training program at Biala in Brisbane in 1978, which in ten years trained 145 indigenous counsellors (Kahn and Fua 1992). Fua was (and still is) also a firm believer in the disease model and in the need for total abstinence (Fua 1987). ‘Social drinking’ was not acceptable. Fua told the Committee that moderation ‘was a very big step backwards as far as alcoholics are concerned. An alcoholic will never be cured but must abstain’ (HRSCAA 1976-1977, p.2897). Eva Kennedy and others in Townsville in 1975 were also keen to start their own treatment which was a ‘blend of AA, individual and group therapy’.

Despite the strong support for AA-style methods which was voiced by some prominent Aboriginal alcohol spokespeople, many submissions, and the Committee members themselves, voiced doubt as to the suitability of AA for Aborigines, especially ‘tribal’ people. The Committee seemed concerned about the Christian connotations of the 12 steps in view of the fact that the Christian missions had often ‘removed the fundamental heritage’ of Aboriginal people (HRSCAA 1976-1977, p.3697). The SA Department of Community Welfare believed that AA programs were not understood by Aboriginal people as they comprised foreign concepts (HRSCAA 1976-1977, p.3587). Dr Archie Kalokerinos (Redfern) believed the ‘heavy hand’ of AA would discourage the majority of Aborigines and that it would only suit a few people (HRSCAA 1976-1977, p.2961). Several medical and professional presenters to the Committee (such as Dr Ward from the NSW Health Commission), admitted that there was great dispute among alcohol experts as to whether alcoholism was a disease (a key tenet of the AA model). Dr Max Kamien reported on his work in Bourke and reminded the Committee that Aboriginal drinking

was associated far more with group psycho-social pressures than with individual psychological need as in the case of the non-Aboriginal ‘alcoholic’ for whom AA was designed (HRSCAA 1976-1977, p. 2741). He noted that Aborigines involved in the Aboriginal Advancement Association in Bourke all drank less, and that full employment and moving off-reserve also helped to moderate people’s drinking.

### **2.3. The separatist position**

The third major thread running through the HRSCAA hearings was the assertion - made by Aboriginal and other contributors - that Aboriginal people should deal with alcohol problems themselves; that they knew best how to deal with their own people. Aboriginal people represented at the HRSCAA also stressed that they could and should deal with these issues themselves; they would run their programs in their own way. Numerous Aboriginal submissions repeated that Aborigines needed their own agencies and workers. For example, it was argued by representatives of the Aboriginal health service at Redfern that Aboriginal alcoholics ‘rarely used white services,’ and when they did so they felt discriminated against. This assertion was contested by two non-Aboriginal clinicians who gave evidence. Chegwidden and Flaherty, who ran the McKinnon withdrawal unit in Sydney - and were said to be the only experts on detoxification to appear before the Committee - told the HRSCAA that they treated numerous Aboriginal clients at their facility. Most clients came from rural New South Wales rather than Redfern in central Sydney. They stated that the retention rate among Aborigines was better than that for non-Aborigines, and that a withdrawal unit such as theirs had no need to distinguish between black and white people (HRSCAA 1976-1977, p.2765).

The separatist argument was associated with domestic self determination policies. Once prohibitions on Aboriginal drinking had been repealed and self determination policies were made official by the Whitlam Labor government from 1972 ('self management' under the Fraser Coalition government from 1976), it was no longer possible to engage in social engineering in order to ‘protect’ Aboriginal people from alcohol abuse. Self determination meant that the role and influence of concerned outsiders (such as

community advisors, missionaries and health professionals) became more tenous. Very much in keeping with the ideology of the times, the simplistic version of self determination policies stressed that Aboriginal communities should be responsible for *all* decision-making and community management, and this extended to social issues including access to alcohol and controlling the post-consumption aftermath. ‘Communities should adopt their own programs to combat drunkenness’ was a commonly-expressed view (HRSCAA 1976-1977, p.436). A DAA submission from the Alice Springs region articulated a position that has since become conventional wisdom, namely that:

*...assistance be given to people to devise their own methods for dealing with [alcohol] problems ... [these problems] cannot ultimately be solved by persons other than Aborigines themselves* (HRSCAA 1976-1977, p.149)

However, DAA’s Tennant Creek office (a few hundred kilometres to the north) took an entirely different approach, submitting that there was no chance of Aborigines coming up with solutions themselves as in their traditional life they ‘had no induced stimulants and hence no controls for stimulated persons’ (HRSCAA 1976-1977, p.1340).<sup>15</sup>

There were also suggestions from both Aboriginal and non-Aboriginal people that Aboriginal drinking was qualitatively, culturally - and maybe even biologically - ‘different’. Once Aboriginal drinking was made exotic in this way, it was natural to imply that only Aboriginal people themselves could understand and deal with it. The arguments for Aboriginal control over services - which were presented to the Committee and became part of the on-going discourse - were predicated upon ideas of *difference* in their relationship to alcohol. Initially these ideas were based loosely on notions of racial difference, and later in the 1980s the relationship was conceptualised as being associated with cultural difference. Several members of the Committee were intrigued by the

---

<sup>15</sup> This is factually incorrect. There is evidence of widespread use of psychoactive substances which were made and ingested traditionally. These include the psychoactive drug *pituri* (*Duboisia hopwoodii*); strong native tobaccos (*Nicotiania* sp.); drinks which induced stupor; and mildly intoxicating beverages (Brady 1991).

potential for biological explanations. There was a suggestion of an adaptive difference between Aborigines and other Australians in gulping behaviour, associated with drinking water out of rockholes (HRSCAA 1976-1977, p.94). Hearing that northern Aborigines handled their alcohol 'better' than Alice Springs people, one member (the Hon. Bill Wentworth) wondered if there might be biological differences between them (HRSCAA 1976-1977, p.444). Dr Archie Kalokerinos, medical advisor to the Aboriginal health service in Redfern (and thus 'endorsed' by the Aboriginal Board of Directors there), believed that Aborigines lacked the liver enzyme which is responsible for detoxifying alcohol (Kalokerinos 1974; Kalokerinos nd).<sup>16</sup> He wanted to give Aboriginal alcoholics massive doses of Vitamin C in order to detoxify the kidneys, having become convinced of its powers to improve the health status of Aboriginal infants when he was working in rural New South Wales in the late 1960s.<sup>17</sup> It is worth pointing out that the nature/nurture debate on problem drinking continues twenty-five years after this. An authoritative review by a team of WHO experts concluded in 1995 that the biological factors affecting drinking behaviour were 'large in number and diverse in nature'. The presence of predisposing factors, they conclude, can only produce an elevated risk, and whether this materialises into a drinking problem will depend on environmental factors (Edwards and authors 1995, p.93).

Aboriginal submissions also spoke of biological differences,<sup>18</sup> and of differences in nutrition (associated with the change to a Western diet) which were thought to make Aboriginal people more vulnerable to the effects of alcohol. John Newfong (an Aboriginal writer and activist) believed that Aborigines were *not able* to consume large quantities of alcohol because white man's food was inadequate in nutritional value (HRSCAA 1976-1977, p.2847). He was probably influenced by a publication from

<sup>16</sup> These suggestions of biologically-tinged difference continue: a West Australian physician wrote in an official Drug Offensive publication that Aborigines suffered from a 'particularly severe form' of alcoholism, which was difficult to treat because they came from a 'pre-scientific culture' (Spencer 1988).

<sup>17</sup> Kalokerinos' work with Vitamin C (1974) was very controversial. Dr Max Kamien, who made a presentation to the HRSCAA declared that he was 'entirely wrong' and that there was no scientific basis for any of his claims (HRSCAA:1914).

<sup>18</sup> This apparent acceptance in the 1970s by some Aboriginal people of biological/genetic differences appears to have hardened into wholesale dismissal of such possibilities in the 1990s. Central Australian Aborigines have demanded that all further research on the genetic or physiological basis of Aboriginal alcohol problems should cease (d'Abbs et al 1994).

Redfern AMS which was written by Kalokerinos and submitted to the HRSCAA (HRSCAA 1976-1977, p.2950). Its introduction reads:

*There are many reasons why the effects of alcohol consumption amongst Aborigines could be different to those observed amongst Europeans. Furthermore, at least some of the loss of normal personal control, including homicide, could be partially explained by biochemical changes following alcohol consumption ... In Aborigines from the moment alcohol is consumed there are almost certainly faults in the essential breakdown system involving the enzyme ethyl alcohol dehydrogenase (in the liver). This is compounded by diets that are refined carbohydrate excessive and mineral and vitamin deficient. The end result is biochemical mayhem leading to disordered brain functions and loss of normal control.*

Similarly, a communication from the NACC (National Aboriginal Consultative Committee) following the publication of the Committee's findings and published in *Identity* (January 1977, p.10) also pursued the biological differences argument. It utilised Kalokerinos' supposed finding of a 'different genetic structure which has the effect of making Aborigines more prone to alcoholic intoxication', to critique the 'wet' position of the HRSCAA:

*Today's government, the committee and its chairman the Hon. Phillip Ruddock, M.P., are in grave error for believing that each Aboriginal community should make its own decision on whether alcohol should be permitted. This is like letting babies into a hospital dispensary to play with dangerous drugs.<sup>19</sup>*

One ongoing problem to be dealt with was whether or not alcohol itself was inherently addicting or whether its addictive powers somehow narrowed down to form a hold on the few who were susceptible to the illness. The alcoholism movement (AA included)

---

<sup>19</sup> Ten years later, in conversation with researcher Tim Rowse, an Aboriginal man compared 'citizenship' (ie the right to drink) as letting scrub-bred bullocks out of a yard to run amok (Rowse 1996, p.134).

stresses that alcohol is only pernicious to a few drinkers - that is, alcohol is not a threat to the entire community, only to those vulnerable to it. What many Aboriginal alcohol activists did was to suggest (see quote above) that they were *all* vulnerable to it, which led, inevitably to the implication that Aborigines were different when it came to alcohol use. Aboriginal representations to the Standing Committee, and indeed other stated positions since then, suggest that Aboriginal spokespeople were - and are still - grappling with different conceptual frameworks within which to explain the nature and causes of alcohol problems. They were also struggling to establish whether, or how, these could be placed in a political context. Many were convinced by the apparent simplicity of the disease metaphor; others spoke of social and historical deprivation 'leading' to alcoholism. Overall, Aboriginal spokespeople took the position that their alcohol problems *were qualitatively different*, and came about for different reasons, than those of others in the population. The (somewhat illogical) argument put forward that Aborigines 'catch' the disease of alcoholism as a result of their dispossession, leads inevitably to the proposition that they must suffer from an idiosyncratic form of alcoholism. Charles Perkins, for example, strenuously denied that there could be any 'innate tendency' on the part of Aboriginal people to drink more (HRSCAA 1976-1977, p.59). However, opening the DAA's evidence to the Standing Committee, he observed that 'Aboriginal alcoholism is related to an identification loss and therefore is a *peculiar form of alcoholism*' (HRSCAA 1976-1977, p.4-6, emphasis added). This proposition survived and was reproduced in the Report of the NAHSPW in 1989 which stated that 'alcoholism is an introduced illness caused primarily by political, social, economic and cultural deprivation' (National Aboriginal Health Strategy Working Party 1989). This construction blends a socio-political explanation for heavy drinking with a disease paradigm.

The belief that Aboriginal people had a particular form of alcoholism, with different antecedents, and different outcomes to those of other Australians allowed (indeed *required*) Aboriginal activists to assert that they themselves are best able to effect programs of rehabilitation 'because they understand the particular problems facing

Aboriginal alcoholics' (HRSCAA 1976-1977, p.5).<sup>20</sup> Benelong's and other similar Aboriginal run programs constituted apparently successful examples of Aborigines doing just that - finding solutions to severe alcohol problems. In addition, the belief that Aboriginal alcoholism was *different* meant that the proponents of the 'dry' position could argue that while 'controlled' or 'social' drinking was fine for non-Aboriginal people, abstinence was the only solution for *Aboriginal* people with drinking problems. At the time, it seemed to be the only model anybody could think of, even if doubts were already being raised about whether alcoholism really was a 'disease', abstinence should be the sole goal of treatment, and whether residential programs were as successful as everyone assumed them to be.

#### **2.4. The outcome of the enquiry**

In its final report, the HRSCAA stressed the need for more emphasis on *prevention*, which it interpreted in part as 'overcoming the causes of alcohol problems'. These causes were thought to be a mix of psycho-social and environmental factors, with the emphasis on the former. But the suggested solutions to these were vague (training for bureaucrats in order to improve relations with Aboriginal communities, and 'adequate consultation' with Aborigines). The report expressed hope for the benefits of 'alcohol education'.

The HRSCAA also stated that efforts towards total sobriety should be encouraged, and in so doing endorsed the 'dry' arguments that had been proffered. Despite concern that AA would not be as successful with 'tribal' as with 'non-tribal' Aborigines, it recommended continued Government assistance to rehabilitation centres (including AA based

---

<sup>20</sup> The negative implications of stressing difference were raised by Dr Charles Gurd at the NT hearings of HRSCAA. He thought more progress would be made if the differences between black and white communities were not exaggerated. He suggested that Aboriginal alcohol problems had become cloaked in a mystique which 'replaces the difficult enough social equations we have learned to apply to the rest of the community, with an entirely new set which defy resolution and invite a cult of nihilism ... nothing can be done' (HRSCAA:283).

centres),<sup>21</sup> until their effectiveness had been assessed' (House of Representatives Standing Committee on Aboriginal Affairs 1977, p.56, emphasis added) The Committee's final report also urged Aboriginal involvement in programs and services, and the need to employ Aboriginal ex-drinkers (but also the need for suitable training). On 'wet' issues, the Committee placed faith in the idea that if the right checks and balances are in place, then 'tribal leaders' and local Aboriginal communities should be able to encourage 'sensible' drinking practices at local premises. It saw no reason why beer canteens on Aboriginal communities should not be commercially viable.

In the event, expediency influenced the political decisions taken as a result of the HRSCAA, rather than any strategic implementation of the recommendations. The Committee had pronounced the situation to be serious and that year, 1977, in an election atmosphere, the Prime Minister indicated that \$750,000 would be made available immediately to develop Aboriginal alcohol programs. In effect an 'election gift', the funds were hurriedly extracted from Treasury and allocated to residential programs - which constituted only one aspect of what was really needed to address the growing problem. As one observer noted, although prevention was the stated priority in the HRSCAA report,

*Decisions were based on economic and political factors rather than the realities of Aboriginal need ... getting drunk Aboriginals off the streets [rather than] looking at the total situation and allocating resources to where they would have the greatest impact ... Nothing was left for preventive programs ... (Wilson 1986, p.11)*

The outcome of the HRSCAA was that *more residential programs were funded*, despite the fact that they were based on principles that were already being questioned by new

---

<sup>21</sup> It must be assumed that the Committee means by this 'attending AA meetings' rather than doing time in a residential rehabilitation centre; however this distinction is not entirely clear. AA itself is not a form of treatment, it is a way of living which encompasses the 12 steps (Miller and Kurtz 1994). Quite separate from AA as a self-help group, is the use of the 12 step program which is often the only option offered to clients of clinics or residential programs.

thinking in drug and alcohol treatment research. In 1979-80 grants from DAA for 40 Aboriginal alcohol programs totaled \$2.2m, of which \$1.4m went to rehabilitation services and \$0.8m to others such as pick-up services and shelters. In 1980 the Program Effectiveness Review of Aboriginal Health noted that little information was available about the effectiveness of these services, expressed some scepticism about the programs, and observed that residential centres were intensive, costly and returned individuals to an unchanged environment (Department of Prime Minister and Cabinet 1980).

Once initiated, the residential programs continued to be funded and to receive the bulk of available funding, year after year. When ATSIC was formed in 1990 and took over responsibility for the substance abuse program from DAA, this included the residential treatment centre funding.<sup>22</sup> In 1992, a national survey of clients of treatment service agencies found that Aboriginal and Torres Strait Islander people were *more likely* to be receiving these residential forms of treatment than non-Aboriginal Australians and had a limited array of treatment styles available to them (Chen, Mattick, and Baillie 1993; Mattick and Jarvis 1993). This assessment is borne out by a study of the goals of treatment service agencies (Brady, Dawe, and Richmond 1998; Dawe and Richmond 1997). Of 178 Australian agencies surveyed, 29 identified themselves as providing services primarily for Aboriginal people, and 18 of these were community-controlled organisations. The rest were State/Territory health/substance abuse services or Aboriginal units within the States. Agencies were asked whether they offered goals of controlled/moderate drinking or abstinence. Fifteen out of the 29 offered programs using only abstinence goals using the Minnesota model (12 steps). Fourteen offered a range of options including brief interventions, harm reduction information, moderation goals and referrals to residential treatment - that is, a broad range of approaches. The agencies which offered a range of treatment options were the State-run agencies. The Aboriginal community-controlled agencies were more likely to offer only abstinence goals and a

---

<sup>22</sup> By 1995, treatment and rehabilitation services, that is tertiary level interventions, still accounted for 74% of total ATSIC funding for substance abuse. A review of the ATSIC program in 1996 found little evidence that resource distribution had been based on local needs and that resources were distributed as a result of established historical patterns (Office of Evaluation and Audit 1996).

limited range of treatment options.<sup>23</sup> The explanation for this distribution is that the Aboriginal-controlled agencies were primarily *residential* services. All but one of the 12 residential programs in the sample were Aboriginal-controlled. These were the respondents who (on the whole) made negative comments about the use of moderate drinking goals and on the usefulness of brief interventions. They are indicative of the type of program which has been insulated from new, alternative, or broader approaches.<sup>24</sup>

### **3. Changes in international positioning on alcoholism**

The HRSCAA had its hearings at a crucial time (the mid 1970s) in the development of theoretical and clinical understandings of addiction, which were taking place both internationally and domestically.

The disease model of alcoholism, first advanced in the United States at the end of the eighteenth century, asserted that those who had 'lost control' of their drinking suffered from the 'disease of inebriety'. Consumers of alcohol were characterised as hapless victims of this syndrome. Over the years, the model was refined until it became the dominant metaphor, taken up by Alcoholics Anonymous and other self-help groups. 'Alcoholism' had been on the agenda of the WHO from the time of its first assembly in 1948. It had a program focus between 1950 and 1955 when E.M. Jellinek worked in Geneva as a consultant for WHO; he was responsible for the WHO definition of alcoholism, and charted the 'phases' of addiction. Jellinek's earlier writings became the orthodoxy within WHO while his later work, which referred to economic factors and the link between overall consumption and rates of alcoholism, was downplayed within the organisation (Room 1984a; Room 1985a). His 1954 paper discussing the 'economic origin' of alcoholism, was a precursor to the changes in thinking which occurred twenty years later.

---

<sup>23</sup> Of the 11 State-run agencies and one Christian NGO, nine offered a range of treatments. Only five out of 18 community-controlled agencies offered a similar range.

Within the WHO, thinking about alcohol problems began to change from the mid 1970s, just as its positioning on health was changing too. As described in Chapter 2, there was a new interest in the social and economic determinants of health, and in prevention rather than bio-medical ‘cure’ being manifest in WHO, and these had their echoes in the alcohol field. Changes in thinking about alcohol within WHO came about partly as a result of the work of the influential Finnish alcohol researcher Kettil Bruun. Under WHO auspices, he and others led an examination of the potential importance of *controls over availability* as a cornerstone of a public health approach to alcohol problems (Ashley and Rankin 1988; Room 1984a). In other words, equal attention began to be paid to the supply side of the equation and to the social and economic determinants of alcohol consumption, as to individual ‘demand’. The old definitions were re-arranged. In 1977 (the year of the HRSCAA) a WHO Group of Investigators published a report which distinguished between the ‘alcohol dependence syndrome’ and ‘alcohol related disabilities’ (which were not defined in terms of disease). Later ‘disabilities’ was replaced by ‘alcohol related problems’. ‘Alcoholism’ was therefore expunged as a category from the International Classification of Diseases in 1977. ‘Addiction’ has been abandoned, officially, since 1980 (Drew 1986). As early as 1980 a WHO expert committee stressed the need for efficient means to detect harmful consumption of alcohol before the health and social consequences became pronounced (Anderson 1996). Room (1984a) suggests that the dual terminology (dependence, and problems) served as a rapprochement between the psychiatric insistence on addictive phenomena and the emergent epidemiological and social science desire to disaggregate alcohol related problems. In fact, ‘alcohol related problems’ has, since then, provided the underlying conceptual framework for ongoing WHO program components (on prevention, national alcohol policies, international action, and stimulating community action).

These changes came about because by the mid 1970s, epidemiological research had begun to document that rather than drinking problems being confined to a discrete group of ‘alcoholics’, a wide range of problems are distributed through the general population,

---

<sup>24</sup> However, staff of some of these programs made comments such as ‘I wouldn’t mind someone coming up and explaining all these things to me. The more I know, the more I can help others’, and ‘I’d like to go to a course, the more experience I get and more I learn, then maybe I can help more ...’

and that people move in and out of problem drinking over time. During the 1970s and 1980s health professionals in various countries were becoming more and more sceptical about the disease concept of alcoholism and about abstinence as the invariable goal of treatment (Lewis 1992a). As a result, the orthodox disease model began to disintegrate, because of the fissures in its core propositions (Drew 1986; Walsh and Hingson 1987). By the 1980s a so-called ‘bio-psycho-social’ view was revisited by Donovan (Donovan 1988). The expression had been originally coined by George Engel as a challenge to biomedicine and as a model allowing for more integrated social, psychological and behavioural dimensions of illness (Engel 1977). Donovan gave it a further airing in the context of the addictive behaviours. As with its original formulation, it was said to be a move away from reductionist views of illness towards a broader, holistic one. Prochaska and Di Clemente (Prochaska and Di Clemente 1986) also proposed what they termed a ‘transtheoretical’ approach to understanding change in the addictive behaviours. And writing in 1985, Room noted the need for a necessarily multidisciplinary approach to understanding and preventing alcohol problems ‘without a hegemony for any particular discipline’s operating model’ (Room 1985a, p.137).

These more nuanced approaches to problems with alcohol provided thoughtful and thorough perspectives on controlled drinking, motivation, the stages of change, relapse prevention, the importance of assessment, and a de-emphasis on labelling (Allsop 1990; Institute of Medicine 1990; Prochaska and Di Clemente 1986). Attention had switched from a preoccupation with treating severe late-stage alcohol problems, to the potential for much earlier interventions, and the role of primary care practitioners in prompting motivation to change among their patients. Prochaska and Di Clemente’s seminal work helped to unpack the solidity of uni-dimensional approaches (of any kind, but particularly the disease model). Also they helped to deepen the analysis of the change process - the idea that there are stages of change and that during the process people require different approaches to help them - they will be open to some and closed to others.

#### **4. Changes within Australia**

In the 1970s and 1980s, at the time when Federal government support for Aboriginal substance abuse was being given largely to residential programs whose methods and philosophies remained unexamined, the Commonwealth was in fact receiving good policy advice on drug and alcohol matters. The Whitlam Labor government had launched the community health program in 1973, and in principle the new emphasis on health prevention meant that the Commonwealth encouraged the States to integrate drug and alcohol issues within a broad range of other health services (Petersen 1985; Room 1985b). The emphasis was to be placed on primary and secondary prevention for members of the population with various levels of risk of alcohol problems. Gerald Milner was advisor on drugs of dependence to the Commonwealth Department of Health in the early 70s. Milner (Milner 1973, p.288) believed that there was a continuum of risk and cost for all alcohol users.

*The disease concept spawns treatment centres, special clinics, agencies and foundations, which are, in practical terms, expensive and socially inefficient...*

*They contribute virtually nothing to prevention, for there are no 'alcoholics' or 'addicts' just ordinary people who have slipped along the social distribution curve for drug consumption and measured ill-effects.*

The House of Representatives committee explicitly rejected some suggestions for prevention strategies that had been made to it, including: the production of low-alcohol beer; an increase in excise on beverages with a high alcohol content; a reduction in the excise on low-alcohol content beverages; a reduction in drinking hours and in the number of liquor outlets (House of Representatives Standing Committee on Aboriginal Affairs 1977, p.64-65). Proposals for 'secondary prevention' - early detection and effective intervention through health services once problems become apparent - were not mentioned at all. This was despite the fact that government endorsement of the principles of prevention dated from 1973. Nevertheless, it should be pointed out that the outcomes or prevention strategies are notoriously difficult to measure, and take time to come to

fruition. At the time there was little hard evidence that the recommended policies would have the desired effect. Some commentators have suggested that prevention policies were largely economically-driven (Petersen 1985, p.175-177). It was only in 1980 that the Fraser Liberal government gave a commitment in principle to alcohol control policies which favoured an overall reduction in alcohol consumption (including the possibility of curtailing the rights of responsible consumers). Nevertheless, primary and secondary prevention had been increasingly articulated from the mid-1970s together with an emphasis on de-institutionalisation in health care.

In 1977, the year in which the HRSCAA reported, the Medical Advisor in Mental Health to the Commonwealth government was Dr Les Drew. Years before, in 1968, he had published an article questioning the basis of the disease model (entitled 'Alcoholism as a self-limiting disease') and had urged a more critical approach to treatment.<sup>25</sup> By the mid-1980s there was a substantial shift of attention away from the 'diseased' individual, to the social and economic forces which promoted alcoholism, the reduction of gross consumption as a way of controlling alcohol-related harm and a public health model of prevention (Ashley and Rankin 1988; Lewis 1988). Guides and definitions within Australia, available since 1989, recommend the discontinuation of the use of the term 'addiction' with respect to alcohol use, and suggest categories such as unsanctioned use, hazardous use, harmful use, dependent use; as well as the classic public health model which considers the drug, the context and the environment which surrounds it (Richards et al. 1989; Zinberg 1984).

Despite these changes in discourse at the international and domestic levels, the broadening debate on ways of understanding alcohol abuse which began in earnest in the 1980s did not appear to permeate into the programs available for Aboriginal people. It did not influence the way they were advised, or inform any strategic planning. We could interpret this absence of guidance 'from above' as an example of the implementation of self determination - allowing Aboriginal organisations to pursue the direction they

---

<sup>25</sup> In 1986 he wrote an article savaging the disease model, saying it had failed to produce the results (Drew 1986).

sincerely believed would ameliorate alcohol abuse. Indeed, the climate of opinion in a society can be multi-paradigmatic and multi-layered, with a number of simultaneous alcohol-explaining models at any given historical moment, as Robin Room has pointed out (Roizen 1991). On the other hand, we could also interpret this failure to disseminate a broader series of intervention possibilities as an example of gross neglect of an increasingly serious health problem. A further possible explanation lies in the fact that until the 1990s, few Aboriginal health professionals undertook tertiary courses in addiction studies or public health which would have exposed them to alternative or critical perspectives on theories of substance abuse. While all three explanations probably have some validity, it is useful to explore further the structural reasons for the failure of this debate to permeate Aboriginal programs.

## 5. Barriers to the dissemination of innovation

The structural barriers to change emanated both from governments and from Aboriginal people, mostly those representing non-government organisations. At the level of government, there was no one department or agency that took on a leadership role in Aboriginal alcohol issues, or which was instrumental in formulating any direction. This was pointed out by the Chair of the HRSCAA during the hearings and has been reiterated many times since then (HRSCAA 1976-1977, p.306). Both the States *and* the Federal government were involved in funding and administering services and programs for Aboriginal people, so there was more than one player involved at the level of government. I have already indicated that the Commonwealth health portfolio was receiving forward-thinking advice on addiction treatment over the period in question (mid-70s) from influential advisors such as Milner<sup>26</sup> and Drew. However, those Aboriginal alcohol programs accessing Federal monies were being funded not through the Department of Health, but through the Aboriginal Affairs portfolio. Having the

---

<sup>26</sup> Milner, for example, wrote a report on 'Darwin Drunks' for the Department of the Northern Territory (prior to the decriminalisation of drunkenness) in 1975 which recommended that a broad range of services were needed: a counselling service, increased admin services, sobering up units, a detox unit at Royal Darwin Hospital, and half way houses (HRSCAA: 262). At the time there were no facilities available whatsoever other than the Royal Darwin Hospital.

relatively specialised program areas of health and substance abuse for one section of the population located beyond the generic health department, undoubtedly contributed to their isolation from the professional input directed into that department (Kunitz and Brady 1995). This was despite the presence within the DAA of a small group of committed professionals.

The linkages between non-government programs and professionals in the field should ideally be through and within the State governments, for Federal departments have always found it hard to provide ongoing support regionally. Part of the failure of the Federal DAA to provide local support to services lay in the unresolved confusion of roles between boards and managers of Aboriginal services. In order to obtain DAA funding, programs had to have a primarily Aboriginal committee or board of management. These committees were composed of ‘well-meaning people in the Aboriginal community’ according to alcohol worker Cyril Hennessy (Hennessy 1981). Hennessy is an Aboriginal man with long-term experience of managing rehabilitation programs and in a critical article published in 1981, he pointed out that in many cases the committees and management did not know what they were doing, that there was frequently confusion and conflict between them, and that there was no management training provided for any of them. The Federal government was unable to provide enough field staff to give them ongoing support, which could have helped to disentangle these problems (Wilson 1986). Realising that it was difficult to provide this regional field-based support network, the Federal DAA granted funds to special Aboriginal health units in the States from 1972, in an attempt to force States to recognise the special health needs of Aborigines and devote attention to them. In New South Wales, the special Aboriginal health unit of the State Health Commission, commenced in 1973, had over 100 staff, about half of whom were Aboriginal, including three alcoholism counsellors and four mental health counsellors (House of Representatives Standing Committee on Aboriginal Affairs 1979, p.81). Such State networks could have assisted the fledgling Aboriginal intervention programs but at the time in the 1970s there was considerable distrust and suspicion directed towards State governments by Aboriginal NGOs. It was difficult for these governments to garner the support of influential Aboriginal lobby groups and spokespeople. As already discussed,

Aboriginal groups pinned their hopes and expectations of direct funding (that is, funding which was not mediated through the States) on the Federal government.

The barriers to change were also lodged within Aboriginal para-professionals and NGOs in the alcohol area, where there were a number of structural and political factors which served to inhibit change. One way of interpreting the insulation of the Aboriginal alcohol programs from outside influences is to see it as an example of isolation brought about by the existence of dense networks of individuals who all know one another. In theories of social networking, this is an example of the *weakness of strong ties*. On the other hand, loose networks of acquaintances (as compared to close friends and colleagues), *weak ties*, tend to be those in which information flows freely among many different individuals and institutions (Granovetter 1973; Granovetter 1983). Granovetter (1983, p.202) proposes that individuals with few weak (that is casual, outward-looking) ties ‘will be deprived of information from distant parts of the social system and will be confined to the provincial news and views of their close friends. This deprivation will ... insulate them from the latest ideas and fashions’. The information to which one is privy is likely to be much the same as that which one already has. Family size affects the number of weak ties, since if family networks are large (as they are in the Aboriginal community) more of the total contacts of an individual are likely to be absorbed in them. In addition, Aboriginal alcohol programs tended to be created using the personnel who were already on hand, rather than seeking ‘professionals’ from outside. Economic insecurity is also linked to strong networks of people (and resistance to innovation) because they are forced to rely on each other, a factor which is also pertinent to the Aboriginal situation in which individuals are poor, and organisations underfunded or perceived to be so (Granovetter 1983; Levy and Kunitz 1981). The scarcity of outward-looking networks among the alcohol treatment providers was exacerbated by the availability of separate funds, which encouraged the formation of further alcohol treatment programs which were not attached to existing health networks.

A significant barrier to innovation existed from the time when these services were still in their infancy, because there was a split between the alcohol programs and the medical

services. I will argue that this allowed for the alcohol programs to concentrate solely on late-stage treatment, and made it difficult for health services to have a role in alcohol intervention. As I will be considering whether earlier, primary care-based alcohol interventions are feasible, this separation is of particular interest.

### **5.1. The separation between health services and alcohol services**

In the early years of the development of the Aboriginal medical services, those people who were instrumental in getting them established showed no desire to be involved in any particular substance abuse programs. The activists and committed volunteer health professionals who established the independent AMSs were concentrating on simply providing basic medical care to people. Dealing with alcohol problems was (and is) not a popular area within medicine (Lewis 1992b).

As we have seen, apart from providing primary health care, the AMSs spread their energies over a range of other issues, taking on a role as centres of political lobbying. This did not go unnoticed. In a pointed critique of the political role of the Redfern AMS, Val Bryant told the HRSCAA that her organisation (Benelong's) was primarily concerned with alcoholism rather than with 'politics, landrights, social and racial questions (which are) a matter for decisions of the alcoholic after he or she leaves Benelong' (HRSCAA 1976-1977, 3053). This comment in itself highlights the split between the two groups. In addition, those involved in the establishment of the AMS who were also associated with the political struggles around health (through NAIHO), and those involved in establishing alcohol programs such as Benelong's - were different groups of people with their own allegiances and agendas. This meant that there was little opportunity for the developing rhetoric and reality of primary health care as articulated by at least some of the AMSs - which included an emphasis on prevention rather than medical models of illness and cure - to permeate through to those running alcohol programs. Ironically, alcohol problems remained lodged within a discourse of illness, disease, and cure - that is, a form of the medical model - while being separated ideologically and physically from the health services.

Not only were the groups composed of different sub-sets of people, there were also ideological fissures between the groups involved in alcohol work and those in the health services. The alcohol workers almost unanimously took a hard abstentionist line on alcohol. This was antithetical to the politically-minded activists in Redfern and other community-controlled services - who held strong views on self determination, equality, discrimination and earlier prohibition.<sup>27</sup> <sup>28</sup> For example, workers at Redfern held a meeting in the early 1970s which discussed the 'positive' aspects of Aboriginal drinking - that Aborigines drank as a communal and sharing activity which differentiated them completely from the isolated, lonely individual white alcoholics.<sup>29</sup> In addition, the health services did not subscribe to the notion that all their workers (and Board members) should be abstainers, which was the unbending principle of many of the alcohol programs. This self-imposed separation between the alcohol programs and the health services on the grounds of whether or not staff or managers themselves consumed alcohol, persists until the 1990s in many instances. Discussing the distinctive roles of the Aboriginal Sobriety Group (ASG) and the Aboriginal medical service in Adelaide, Basil Sumner who is a manager of the ASG said,

*ASG has strong rules. The old people who started ASG in 1979 said no one on the committee should consume alcohol, and no staff should. So if we worked under health, that committee won't have those rules. I won't have a chair who drinks, telling me what to do!*<sup>30</sup>

<sup>27</sup> In Melbourne, the Victorian Aboriginal Health Service (established in 1973) had no intention of promoting a rehabilitation program for alcoholics because 'We do not regard people who drink excessively, because of overwhelming political, social and economic pressures, as alcoholics. We consider their problem a social, political and economic problem to be treated as such' (cited in Nathan 1980:25).

<sup>28</sup> The antipathy between the health services lobby and the alcohol programs lobby continues until the present. In 1989 the NAHS warned against funding specialist alcohol treatment agencies arguing that most AMSSs are involved on a daily basis in the treatment of patients with substance abuse problems. While this may be true there is little evidence that the health services were actively pursuing innovation or attempting to train their staff to intervene with patients presenting with dysfunctional drinking. By 1989 it was too late for the health services to be claiming control over alcohol issues. Independent resources for the alcohol services had allowed for the creation of separate political allegiances.

<sup>29</sup> Thanks to Paul Torzillo for this information.

<sup>30</sup> Basil Sumner pers. comm. 7 July 1998. In this case, while the health service and ASG are separate organisations albeit under the same roof, a key individual in each organisation holds the chair of the other organisation, allowing for networking. As it happens, these two individuals are siblings. Representatives

The Aboriginal alcohol programs found that they could attract independent funds from DAA. This had been possible since the early 1970s. This funding provided independence from other Aboriginal groups (such as AMSs) and allowed for the separate accumulation of prestige. Val Bryant claimed to the HRSCAA that Benelong's Haven was the 'best funded' Aboriginal program (HRSCAA 1976-1977, p.3053). The availability of funding also *perpetuated* the ongoing formation of separate services, rather than attaching them either to existing Aboriginal health services or to existing State-run drug and alcohol services. A DAA (New South Wales) submission to the HRSCAA drily points this out, saying:

*The availability of Departmental funds has stimulated Aboriginal efforts to develop separate treatment facilities designed specifically for Aborigines. This trend may be contrasted with another possibility, namely, encouraging general community treatment facilities to become responsible to Aboriginal needs and if necessary to develop units for the treatment of Aborigines within the general system (HRSCAA 1976-1977, p.2677).*

## 5.2. Competing agendas

Apart from some unease in the relationship between the health service and the alcohol workers, there was also open discord within the key Aboriginal alcohol workers and spokespeople operating in Sydney at the time. The Hansard record reveals how the different agendas, allegiances and ideologies of the various parties made any combined or consistent approach to alcohol prevention and treatment virtually impossible.<sup>31</sup> There were several different Aboriginal groups working on the alcohol issue in Sydney in the

---

from ASG attended the Healing our Spirit Conference in Alberta (July 1992) which reinforced their policy. Their report on the Conference read: 'The goal of all alcohol recovery programs (in Canada) is total sobriety for indigenous people. The rationale is similar to that of ASG where to drink is not to be Aboriginal. 'Drinking is not Indian' is a common message throughout Canada ... ASG practices what is preached. All staff are sober and most staff have at some time or another been through a recovery program.' (Sumner et al 1992:4-5).

late 1970s. Benelong's Haven ran its two 'half way houses' based strictly on the 12 steps and abstinence. The Redfern Presbytery was associated through Shirley Smith (known as Mum Shirl) with the AMS, and was run by the Catholic church. It offered food and shelter to down and out Aborigines in central Redfern. Alcohol was allowed on the premises. Within the Redfern AMS itself was Dr Archie Kalokerinos, who wanted to treat Aboriginal alcoholics with Vitamin C. Kalokerinos was opposed to Benelong's Haven and was anti-AA. The Catholic Church (Father Ted Kennedy) also ran a country program for alcoholics called Karakunba. The program, however, was not based on sobriety but on a ration of alcohol. This meant that Val Bryant and the Catholic program were vehemently opposed to one another. In the submission from Benelong's Haven to the HRSCAA the author (presumably Ms Bryant) wrote:

*The use of Government money to supply Aboriginal alcoholics with alcohol is a mark of shame on the Federal Health Department, the New South Wales Health Commission and the Department of Aboriginal Affairs. The killings, rapes, bashings, robberies and deaths of unattended alcoholics are a scandal on the Australian Nation. The ability of a group connected with the Roman Catholic Church to secure funds to carry out this despicable action despite lack of any results and lack of any knowledge of alcoholism is ample evidence of the power of the Missionaries in Aboriginal Affairs. All of the above named departments are aware of this situation - all choose to ignore it. The Catholic Church also chooses to ignore it (HRSCAA 1976-1977, p.3055).*

There was also a short-lived National Aboriginal Campaign Against Alcohol and Drug Abuse (NACAADA) run by Aboriginal Harold Hunt (employed by the NSW State government), and supported by the State Health Commission, as well as by significant figures such as Chicka Dixon. The organisation planned to set up national, State and regional offices, which would have required the expenditure of large-scale funding even

---

<sup>31</sup> Discussing his 'strength of weak ties' network theory, Granovetter asks the reader to imagine a 'community completely partitioned into cliques, such that each person is tied to every other in his clique and to none outside. Community organisation would be severely inhibited' (Granovetter 1973:1373).

before any services were delivered.<sup>32</sup> Supporters of this organisation were all in favour of the purchase of the Abercrombie Hotel in Redfern and its transformation into an Aboriginal 'detox' unit. Benelong's was opposed to this idea, with Val Bryant comparing detox units to service stations. Ms Bryant interpreted the State government support for the proposal as tantamount to establishing a parallel program to Benelong's in a deliberate attempt to undermine it. Also offering services to Aborigines in Sydney was an existing withdrawal unit at Rozelle Hospital, a mainstream facility which nevertheless had a clientele 10% of which was Aboriginal. The two non-Aboriginal clinicians involved supported both Benelong's and the ongoing need for the supportive structures like AA.

In the midst of these competing groups with different agendas, the existence of dense networks of people, the lack of 'weak' ties, and the jostling for funding, it is hardly surprising that few links were made with bodies who could help to plan treatment regimes and disseminate innovative ideas to the increasingly isolated Aboriginal programs. At the time, of course, there was little around that *was* new - the changes in approach began in earnest in the 1980s. But had the links been made, the lines of communication would have been ready. The Aboriginal programs were instead allowed to continue on their own, having neither links with Aboriginal health services nor with government drug and alcohol agencies. In 1996 a review of long-term residential treatment programs observed,

*There was little evidence of any effective links between Aboriginal treatment programs across Australia or between programs operated by Aboriginal councils/agencies and those operated by other organisations. There is a need to develop such a network to encourage the sharing of successful treatment strategies for Aboriginal people (Ernst and Young 1996, p.82)*

---

<sup>32</sup> Bill Wilson pers. comm. 27 July 1998

### 5.3. The legacy of the 1970s

This was a formative period, in which positions were taken and decisions made about approaches to Aboriginal alcohol problems (both by governments and by Aboriginal groups) which had a lasting influence. It is also an interesting period because of the dissonances and contrasts inherent in it. For example, despite the potential for misinterpretation, many Aboriginal spokespeople at that time publicly expressed views which favoured racial, biologically-based explanations for their alcohol problems. These are explanations that are no longer in favour. They argued that their use of alcohol was different, came about for different reasons, and required different approaches to that of non-Aborigines. Notions of ‘race’ and ‘culture’ became blurred in this discourse.<sup>33</sup> I have suggested that these constituted sense-making strategies which allowed for the injection of historical and political elements into Aboriginal understandings of the depth and severity of their alcohol problems. These strategies also made possible the assertion that Aboriginal people should be managing their own services.

Another contrast I have identified in this period is that two opposed approaches to indigenous health were being pursued by Aboriginal spokespeople. The alcohol spokespeople were promulgating a reductionist, disease-based model of alcoholism, for which the ‘cure’ was residential treatment once a person had reached rock bottom. This was in stark contrast to the increasing emphasis on primary health care and a multi-dimensional model of health (as promulgated by WHO) which was filtering into the AMSs. As I have indicated, international and domestic approaches to dealing with alcohol problems in the general population underwent a gradual shift to a much broader, inclusive perspective. In a sense, these were much more ‘holistic’, stressing a continuum of risk, and the combined influences of drug, set and setting. As I have shown in previous chapters, the community controlled health services were downplaying the bio-medical

---

<sup>33</sup> Ian Anderson, a Koori intellectual, argues that Aboriginal people do utilise aspects of racial discourse (such as notions of ‘blood’) when speaking of their identity, but that this is only to be expected when those identities have been formed within the context of colonial relations and the hegemonic language of race (Anderson 1997b). Discussing reactions to the Human Genome Diversity Project, Kohn observes that some Aboriginal people have come to speak of their identity as having a biological basis, with culture and history forming a sort of superstructure (Kohn 1996).

approach to Aboriginal health, and yet the community controlled *alcohol* programs were saying that Aboriginal people who drank to excess had a progressive incurable disease.

I have analysed the structural impediments to the dissemination of broader approaches and shown how the ongoing division of Federal-State responsibilities for Aboriginal health were a part of this. Another impediment was a widespread view that 'the people' themselves could solve these severe alcohol problems, and that they knew best which approaches would work. While this dovetails with the idealism of community participation and the ideology of primary health care, in effect this suggestion transfers the responsibility for resolving the complexities of dealing with alcohol problems onto untrained, lay members of the public, notwithstanding their Aboriginality, or their drinking histories (Rifkin 1986). The record of the HRSCAA investigations reveals that there were also many different perspectives among practitioners, clinicians and researchers at the time. In the Aboriginal field there were warning signs signifying deepening confusion about the issue of access to and control of supply, the extent of 'traditional' local controls, and approaches to treatment. At another level, the splits within the Aboriginal community (illustrated in the case study of Sydney) between the health service and the alcohol practitioners, together with the intransigent positions of several influential individuals, also acted as a barrier to the establishment of ongoing professional and supportive links which could have been a conduit for innovation. The funding process itself encouraged and exacerbated these fissures between the health sector and the alcohol programs by granting independent funds to the alcohol programs out of Commonwealth sources. These untied grants came without performance requirements, advice on best practice, or the expectation that the programs would network with local health authorities.

## **6. The shift to theories of cultural loss**

By the 1980s, the discourse within indigenous politics as a whole began to make some shifts of its own, which extended into health issues. The idea gained currency that cultural loss is associated with a range of health problems, including being implicated in

the etiology of alcohol abuse. Cultural affiliation, renewal and identity were said to assist in healing and recovery from addiction, and even to prevent addiction from occurring. The idea that cultural identity can inoculate against drug or alcohol abuse stems from indigenous interpretations of etiology: that drug and alcohol abuse arises from and is exacerbated by deprivation and the erosion of cultural integrity. The reconnection of the Aboriginal person with his or her cultural and spiritual roots is, from this perspective, essential to recovery and well-being. This loss of cultural identity is often depicted in Aboriginal discourse as a kind of ‘fall from Eden’, an imagined state which existed in Australia prior to 1788, and which can be redeemed by the reclamation of identity.<sup>34</sup>

The self-conscious construct of ‘culture’, as something that could be workshopped and debated, seems to be a product of the 1970s. For example, in 1973 there was a workshop on ‘Culture and Identity’ in Darwin, at which it was hoped the tribal leaders would discuss which elements of traditional society should be retained. It was hoped that the ‘tribal’ Aboriginals would help other Aboriginals who had ‘lost their culture’ to find out more about the Aboriginal way of life and customs.<sup>35</sup> Ideas about cultural affiliation and regeneration began to be influential. Links were made from the late 60s on with overseas indigenous groups who shared this discourse. There were representations to the United Nations forums on indigenous and minority populations, and there was an increasing rate of exchange and travel between indigenous groups. In a sense, this was an early form of globalisation, an indigenous version of the acceleration taking place in global communication. The path between North America and Australia became well-trodden. Aboriginal people in Australia were increasingly exchanging visits - particularly with Canada - attending training courses, and Canadian Indian consultants were being hired to work in Aboriginal programs (Brady 1995b; Hazlehurst 1994). They brought with them North American approaches to addiction. The developments and links with North America reinforced disease- and abstinence-based models of treatment. The Canadians who came to influence Aboriginal programs were unanimously anti-moderation or the possibility of ‘social’ drinking. They expressed doubts about the idea of ‘prevention’.

<sup>34</sup> In order to promulgate a pre-contact ‘Eden’ it was necessary to adhere to the view that this imagined state was drug- and alcohol-free.

<sup>35</sup> *Aboriginal News* 1(1) June 1973:10

Their residential programs were said to be a blend of the 12 steps and indigenous spirituality - just as Benelong's Haven had described itself nearly twenty years earlier.

### 6.1. The Canadian Indian influence

Chicka Dixon was one of the first prominent Aborigines to examine drug and alcohol programs in the United States and Canada. In August 1975 he travelled there on an Aboriginal Overseas Study Award, with a focus on Indian welfare, prison and alcohol programs. In Alberta, Canada he visited the Nechi Institute (a training centre for indigenous addictions workers) and its associated organisation Poundmakers Lodge (a residential addiction treatment centre for indigenous clients). He met a Cree Indian from Saddle Lake reserve, Eric Shirt, who was at the time the director of Nechi.<sup>36</sup> Dixon observed in his diary that Poundmakers was the best program he saw overseas. He enthused about the possibility of such an organisation being started in Australia. He noted that 'they have offered to include Aborigines in their 12 months training program or alternatively, have offered to send at least four of their experts to Australia to train Aborigines on the spot'.<sup>37</sup> In 1977 Danny Colson, an Aboriginal man working for Woma (a South Australian Aboriginal alcohol program) had also visited the Nechi Institute and announced that Australia was 'still in the dark ages in the alcohol treatment field', being about ten years behind the North Americans. Both Colson and Dixon were impressed with the large-scale training of indigenous counsellors that took place at Nechi, as well as the apparent success of residential treatment based on the 12 step model that took place at Poundmakers Lodge.<sup>38</sup> In 1990 Chicka Dixon's suggestion that a similar program be developed in Australia finally bore fruit, when indigenous trainers from Canada associated with the Nechi Institute took up consultancies in Australia.<sup>39</sup>

---

<sup>36</sup> Harry Penrith, better known as the Aboriginal activist Burnham Burnham, had also just visited Nechi.

<sup>37</sup> *Aboriginal Health Worker Journal* 2(2) June 1978:56

<sup>38</sup> *Aboriginal News* 3(4) 1978:13. The Nechi Institute also received favourable mention in submissions to the HRSCAA, for example by the South Australian Department of Community Welfare, HRSCAA:3591.

<sup>39</sup> However, these people were not staff of Nechi itself, but independent consultants, some of whom charged high fees for their services. Soon after his 1975 visit, Chicka Dixon had proposed that Mr Shirt should be offered a consultancy in Australia, but his fee of \$250,000 was considered at that time by DAA to be too high (Pers.comm. Bill Wilson 27/7/98).

Although some consultants ranged widely across the country responding to individual invitations from Aboriginal groups, the major focus for Canadian involvement in the Aboriginal alcohol field in the 1990s was in Alice Springs.<sup>40</sup> There, Aboriginal organisations had been actively engaged in research and interventions into alcohol misuse for some years. The Aboriginal media association CAAMA had run a local 'Beat the Grog' campaign; an Aboriginal Alcohol Awareness (AAA) group (originally Aboriginal Alcoholics Anonymous) had been formed in 1989; and several pieces of research had been commissioned. Local Aboriginal organisations had organised formal representations on supply issues concerning the licensing conditions of roadhouses, supermarkets and hotels in and around the town. There were bush meetings in and near Alice to discuss alcohol issues. The Aboriginal Issues Unit of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) organised a meeting in August 1989 which recommended a strategic policy for the region, on the grounds that the existing programs were uncoordinated and sometimes non-complementary. In November 1990 another meeting was held at Hamilton Downs, at which Tangentyere Council (representing Aboriginal town-dwellers in Alice Springs) proposed a 'Planning Unit' that would report on a long-term plan for the development of Aboriginal alcohol services in Central Australia. This plan was inspired partly by a statement from the National Aboriginal Health Strategy (1989) that there was an urgent need to develop strategies to facilitate a safe and sensible attitude to alcohol use. Early intentions were that *all* funding for Aboriginal substance abuse would be channelled through the unit, and that it would produce a long term strategy to integrate 'educational, training, counselling, co-dependency and rehabilitation services with treatment programs and research and monitoring functions'<sup>41</sup>. By February 1991 this 'planning unit' (known as CAAAPU, Central Australian Aboriginal Alcohol Planning Unit), had come into being and was operating out of an office at Congress Farm<sup>42</sup>, funded by Commonwealth Health and ATSIC.

---

<sup>40</sup> I am grateful to Pamela Lyon, Edward Tilton, Carol Watson and Bill Wilson who were involved in these processes and who helped me with the chronology of events.

<sup>41</sup> CAAAPU made a submission describing these aims to a wide ranging enquiry into reducing alcohol use and abuse conducted by a Sessional Committee of the NT Legislative Assembly (Legislative Assembly of the Northern Territory 1991).

At around the same time, in April 1991 Andy and Phyllis Chelsea, two Shushwap Indians from a community in British Columbia, visited Australia to attend a conference in Alice Springs organised by the Australian Institute of Criminology ('Healing our People. Aboriginal community justice and crime prevention forum'). A film entitled 'The Honour of All' documenting their achievements in controlling alcohol abuse at their community Alkali Lake, was viewed by hundreds of Aboriginal people in Central Australia at that time, and was also shown on Imparja TV.<sup>43</sup> Eric Shirt, whom Chicka Dixon had met at the Nechi Institute in 1975, also attended the conference. Within weeks, CAAAPU was investigating funding sources to send Aboriginal people to the Nechi Institute for training in Canada. Despite the original (ambitious) plan that CAAAPU would be able to coordinate a *wide range* of approaches to alcohol problems, CAAAPU began to focus on drawing together a core of committed people who agreed to go all out to develop an Aboriginal-controlled residential treatment centre for Alice Springs. By the time CAAAPU's own strategic Grog Action Plan ('The Way Forward') was completed and published in January 1992<sup>44</sup> - a report which carefully examined an integrated approach - the focus had irrevocably shifted to 'the Canadian approach' - which relied fundamentally on a residential treatment program for chronic drinkers and a linked training program for alcohol workers. It was based on the linked organisations the Nechi Institute and Poundmakers Lodge, in Alberta.

Eric Shirt (by then an independent consultant and member of the governing board of the Nechi Institute) had visited Australia in October and November 1990 at the request of Aboriginal activist Bobby McLeod of Nowra, NSW,<sup>45</sup> and made a series of subsequent visits. At that time Shirt gave a talk at ATSIC in Canberra which was attended by ATSIC

---

<sup>42</sup> 'Congress Farm' is land owned by the Aboriginal organisation Congress, located just south of the town which was originally intended as an alcohol rehabilitation centre based on agriculture.

<sup>43</sup> The film was also viewed by Aboriginal people across the country. I found a family watching it in their house at Amanbidji, a remote Aboriginal-owned cattle station west of Timber Creek, NT in July 1992. The film has attracted visitors to Alkali Lake who seek inspiration for their own sobriety (For a discussion of the consequences of the film on the people of Alkali Lake, see Palmer ).

<sup>44</sup> This report was prepared by Pamela Lyon, an Alice Springs-based researcher who had been hired by CAAAPU and who had already undertaken a thorough review of the literature on prevention, intervention and treatment strategies relevant to indigenous people.

<sup>45</sup> McLeod was intent on establishing an Aboriginal 'self-healing centre' on the New South Wales coast, which would involve indigenous people from many countries visiting, building teepees and sweat lodges and sharing their healing traditions. (See Hazlehurst 1994:109-115).

central office staffers and the Queanbeyan regional manager as well as health department staff working for the National Campaign Against Drug Abuse. On that occasion he was described as 'one of the world's leading experts on treatment and rehabilitation programs for alcoholics in indigenous people'. His presentation and subsequent networking among Aboriginal people resulted in invitations for him to speak to Aboriginal groups in different parts of Australia.<sup>46</sup> Canadian consultants including Shirt himself became residents of Alice Springs when they were hired on a fulltime basis to promote and run a training program for Aboriginal alcohol workers at CAAAPU. The links between Canada and Australia (specifically between Nechi/Poundmakers and Australia) were cemented further as a result of the *First Healing Our Spirit Worldwide* conference for indigenous people which was held in Edmonton in July 1992; some estimates suggest that up to two hundred Aboriginal people from Australia attended.<sup>47</sup> By October 1992 a residential treatment program was operating at CAAAPU on a model largely imported from Canada, including a version of the Canadian 'smudge' or smoking ceremony. Many Aboriginal people in the local alcohol field had reservations about the wisdom of transplanting a model from another indigenous group. Some grumbled that Aboriginal people had 'their own thing' going already, and did not need Indians to tell them what to do. For example, a spokesman for another alcohol program in the region observed that 'the Aboriginal people at Injartnama have reservations about the American Indian involvement in what is seen as a place for revival of Central Australian Aboriginal Cultural activities together with their answer to the alcohol problem'.<sup>48</sup> CAAAPU became so identified with the Canadian Indians that it was known colloquially in the Northern Territory as 'the Canadian program'. The role of the Canadians in activities in Central Australia was curtailed in June 1994 when they were sacked from CAAAPU (Rowse 1996). CAAAPU

---

<sup>46</sup> Mr Shirt was a guest speaker at the Alice Springs Criminology Conference in April 1991; and at the Public Health Association Conference focusing on the health of indigenous people in Alice Springs, in October 1991. He attended the Queensland Drug and Alcohol Authority's Winter School in the Sun in Brisbane in July 1993. These conferences provided the Canadian visitors with a useful network of Aboriginal people from across Australia.

<sup>47</sup> This 'World Indigenous Conference Promoting Addiction Free Lifestyles' was the first event to provide a forum specifically for indigenous people to discuss alcohol and drug abuse. Its flyer invited indigenous groups to 'share the stories and programs of healing that continue to strengthen the foundation of our cultures'. It also invited participants to bring their 'traditional dance wear to join in the Inter-Tribal Dance'

<sup>48</sup> Injartnama Village, A submission, 1991.

itself was de-funded in December 1994 and its training and residential functions came to an end. The program re-opened in 1998 with new funding for ten residential beds.

## 6.2. The policy implications of these developments

In retrospect, many Aboriginal and other observers view the activities of these consultants as a skilful marketing exercise, in which training modules (primarily based on outdated American psychology and the 12 step program) were sold and re-sold to different Aboriginal groups, and for which they were paid substantial consultancy fees out of the Aboriginal health budget.<sup>49</sup> One prominent Aboriginal alcohol worker referred to the Canadian model as 'AA with a smokescreen'.<sup>50</sup> Fears of a 'cultural takeover' were probably unfounded however, as the actual content of the program documents presented to CAAAPU and other organisations by Canadian consultants was more oriented to popular (and some outdated) psychology than to indigenous culture. Indigenous clients being trained at the Nechi Institute are exhorted to 'Walk the Walk' as well as 'Talk the Talk', and the use of the 'genogram'<sup>51</sup> is ubiquitous in Canadian native treatment. The marketing pitch utilises a persuasive mix of 12 steps rhetoric, indigenous culture-jargon and adaptations of native religious practices such as burning sweetgrass. Some have questioned whether these indigenous consultants presented an *indigenous* perspective, or simply a North American perspective - a rerun of the war against drugs, a unitary focus on abstinence, the progressive disease model, on residential treatment, and an antipathy to harm minimisation. After attending an indigenous drug-free conference in Cairns

<sup>49</sup> It was clear that the Canadian Indian consultants distributed training materials from Canada which had not even been edited to suit Australian circumstances. For example the 'Reader for Intervention and Assessment' distributed to clients at CAAAPU and ostensibly prepared specifically for their needs, refers to DIAND (Department of Indian and Northern Development, the Canadian equivalent of DAA), CHRs (community health representatives, the Canadian equivalent of Aboriginal health workers), RCMP (Royal Canadian Mounted Police), and 'bands' (a term referring to collectives such as communities, or 'tribes'). Another document prepared by Eric Shirt and Associates, entitled 'Treatment Program Overview' provided to Rockhole rehabilitation program in Katherine as part of a consultancy to that organisation, and ostensibly designed specifically for them, inadvertently still contained references to FORWAARD (the Foundation on Rehabilitation with Aboriginal Alcohol Related Difficulties) in Darwin, who had *also* hired the consultant.

<sup>50</sup> Betty Pearce, Pers. comm.

<sup>51</sup> A genogram is a family tree showing family structure and functioning, deriving from a 1984 publication *Family Ties that Bind* by R.W. Richardson. Advanced Counsellor Training at Nechi is based on the Family Therapy movement and utilises work by Virginia Satir, Lawrence Shulman and E.H. Coppersmith.

(which hosted American representatives of such organisations as National Association for Children of Alcoholics and Adult Children of Alcoholics), the Director of a respected Australian drug and alcohol resource agency (CEIDA) asked,

*How relevant is current government policy for Aboriginal people if there is a complete rejection of harm minimisation and if abstinence is considered the only solution? ... are Aboriginal people hearing an indigenous perspective or a North American perspective? What are the implications for Aboriginal communities if it is the latter? How alike are the cultures of North American and Canadian Indians to Australian people? How different are they?*<sup>52</sup>

These are indeed valid questions, particularly in view of the utilisation of precious Aboriginal health funds, and funds earmarked particularly for substance abuse from the post-RCIADIC grants. There are also ethical questions raised by the activities of some consultants. Despite having been sacked from Alice Springs in June 1994, one Canadian Indian consultant received a further \$100,000 consultancy in December from an ATSIC regional council in another State. Intent upon discovering evidence of the 'disease' of alcoholism, he attempted through a visiting medical practitioner, to obtain blood and hair samples from Aboriginal clients of a residential alcohol program. He also insisted that all residents forgo any existing medication (such as for diabetes, or depression)<sup>53</sup>, and sold clients vitamin supplements he imported from Canada. This behaviour finally resulted in his dismissal. However, at the invitation of other Aboriginal groups, he continued to travel and give presentations in different parts of the country. As a result, several Aboriginal organisations subsequently sent funding submissions to Canberra for millions of dollars to build residential alcohol treatment centres.

---

<sup>52</sup> Connexions 14(5):18, 1994

<sup>53</sup> Pers.comm. from the medical practitioner concerned. Proponents of 12 step programs often make rules such as this; all medication is seen as 'drugs' which unnaturally prop people up.

### **6.3. An influence beyond their numbers**

It is important to analyse the factors which allowed these developments to take place. There are several ways of understanding the ease with which a very small group of visitors proved to be so influential in the sensitive and contentious area of Aboriginal alcohol misuse. Their most important, and arguably most influential, attribute was undoubtedly that they were indigenous. What came into play was what Sahlins has termed the power of a 'universal nativism' (Sahlins 1995, p.65; Wilmsen and McAllister 1996). This sense that indigenous relatedness is a universal phenomenon serves in itself to loosen the links with that which is non-indigenous. This means that the solutions to Aboriginal alcohol problems were less likely to be sought 'at home' among professionals close at hand, but inclined Aboriginal groups to receive the message from Canada warmly and uncritically. The shared histories of colonialism and cultural disintegration among indigenous groups extend to a perception that they also share similar drug and alcohol problems - or at least that their substance abuses stem from similar origins, such as dispossession. Many Aboriginal commentators travelling overseas remark on the pleasure of recognising this similarity. Marian Hansen, a prominent Victorian Koori, returning from the Healing Our Spirit conference in 1992 said:

*It became quite clear that we as Aborigines of various countries suffer from very similar fates especially the cultural genocide, dispossession and continued oppression. Because of our similarities we have and suffer from similar problems, particularly since alcohol and substance abuse are historically foreign to our culture, there is an urgent need to revive our culture and instill pride and dignity among our people so they can be thrivers and not survivors.<sup>54</sup>*

Another Aboriginal woman remarked,

---

<sup>54</sup> Cited in a publication from Victoria Drug and Alcohol Services, entitled 'Koorie Day completes successful Autumn School, 1993.

*Our cultures are so similar that we could walk hand in hand, we really could. We talk about our Dreamtime, they talk about their creation stories. We really and truly are brothers and sisters (Wroe 1995, p.10).*

Associated with the sense of a shared indigenous identity, was the appeal of the esoteric. Although the content of the training programs and the conference presentations made by the Canadians relied on popular Western psychology, they also introduced ritual paraphernalia and practices from North America (pipe ceremony, eagle feathers, sweetgrass ceremony, and talk of sweat lodges).<sup>55</sup> Attracted by the appeal of these exotic manifestations of another indigenous people, many Aboriginal people were unabashedly fascinated to meet 'Indians'. At one meeting, an Alice Springs Aboriginal man was heard to say in greeting, 'I've always wanted to shake the hand of a real Red Indian'. The Indian consultants invariably adopted the outward and visible markers of Indian identity - long black hair worn in braids, turquoise and silver belt buckles, the beaded choker worn around the neck. Denim jeans, brightly coloured shirts and cowboy boots completed the display. Apart from the perceived brother- and sisterhood between indigenous peoples which facilitated the role of the North Americans, there is little doubt that in Australia, Aboriginal people also welcomed their approach because it was persuasively (and quite unashamedly) presented as a 'magic bullet'. Using examples such as Alkali Lake B.C., and Saddle Lake, Alberta, the speakers repeatedly described how twenty years before in these places, there was universal drunkenness, high unemployment, the culture and ceremonies had 'died', and that after people started to attend treatment centres there was 90% sobriety, Indian ownership, people with university qualifications - the changes in fact, are (re)presented as being almost miraculous (Hazlehurst 1994, p.117; Hodgson 1996).<sup>56 57</sup>

---

<sup>55</sup> Another Canadian Indian visitor to Western Australia (not associated with Poundmakers Lodge) was asked if he would build a sweat lodge for the Aboriginal people of the remote town of Wiluna (Pers. comm. Clive Linklater 1994).

<sup>56</sup> In a presentation in Alice Springs in 1993, Eric Shirt referred to treatment centres as 'miracle machines' (Shirt 1993).

<sup>57</sup> In fact, the people at Alkali Lake were not solely or even primarily influenced by attending the Nechi Institute or Poundmakers Lodge, despite the frequent use of the Alkali Lake example by proponents of Nechi and/or Poundmakers. The Shuswap community there had been exposed to the 'Durieu' system in the 1890s which created a Catholic Indian state within communities. This system imposed strict social order, temperance and a regime of physical punishment (Furniss 1987). In the 1970s and 1980s, community

The widespread (though not unanimous) acceptance of the Canadian model by Aboriginal people was also associated with the fact that the Canadians provided an external source of *validation* for the Aboriginal treatment movement. Aboriginal alcohol workers are not part of the treatment establishment in Australia, and suffer from piecemeal and inadequate training as well as lack of status - perhaps even a sense of inferiority. They lack the official support provided to Aboriginal Health Workers, for example, who have their own journal, and numerous (albeit fragmented) training programs. The up-beat presentations by Canadian Indians emphasised the *number* of treatment centres, the *high levels* of staffing, the *mass* treatment and training of hundreds of Indian clients and counsellors, and above all the *structured* and professional nature of their programs. In his public presentations, Shirt also frequently stressed the quality of the facilities available for those undergoing treatment in Canada, alluding to the makeshift quality of some of the Australian residential facilities:

*How does general society treat diseases? Where do they put them? Where do they put them? Right here in hospital, nice facilities. You know something? Some place that says we care and we would like you to get well. Not some dump that, that God! I would be better living out on a river bed. You have to change the attitude towards the alcoholic. That's one place. And when you build treatment centres, Poundmaker's Lodge: okay, and when you get a choice between Poundmaker's and the Hilton, you choose Poundmaker's (Shirt 1993, p.5).<sup>58</sup>*

Not only did the Canadians hold up a model of high-class facilities to house those being healed, they impressed Aborigines with the structured and the established nature of their

---

members attended treatment programs in many *different* locations so that by 1985 almost every adult had spent time in a treatment centre - not just the one at Poundmakers. The two initiators of the sobriety movement at Alkali Lake, the Chelseas, started an AA group. They also did 'Lifespring' training - a personal growth technique using confrontational techniques based on the core philosophy of Erhardt Seminar Training (EST); other community members followed (Palmer 1994:50; Pers. comm. Elizabeth Furniss).

<sup>58</sup> The condition of facilities used for Aboriginal and Torres Strait Islander people was indeed found to be generally inferior to those of programs for the majority population, in a review of long-term residential treatment conducted in 1996 (Ernst and Young 1996).

treatment ideology (firmly grounded in the view that alcoholism is a treatable disease), and with their professionalism. Aboriginal observers noticed this:

*From our brief stay it appears that generally the Alberta experience for native Canadian indigenous people appears to be one of innovation, professionalism and progress ...*

*Great emphasis is put on developing highly structured programs incorporating detailed relevant education and training for staff as counsellors and trainers. The inescapable conclusion is that great progress is being made in Alberta. In contrast, the Australian experience is woefully behind and particularly in levels of resources and funding of community controlled programs for alcohol, substance abuse and associated issues.*

*Poundmaker treatment is built around a highly structured 28 day process ... There are two Treatment Directors, a psychologist, medical, dental, administrative, finance, counselling and other support staff and consulting professionals ...*

*This is the singular lesson from what Canada is doing in detailed training and program development – ‘If you have not got structure, you have no program’ (Sumner, Sumner, and Kilgariff 1992, p.1,6-7).*

The Canadians thus provided Aboriginal people who were *already* oriented towards 12 step residential programs with legitimisation of their existing ideology, by presenting this approach as being practised in a professional and competent manner, endorsed by the weight of Canadian government funding, and sophisticated in its meshing of Western psychology and cultural and ceremonial practices. The Canadians legitimated the long-standing argument for Aboriginal control of treatment services, and reinforced the perception that alcohol programs had been hard done by. Although as I have mentioned, treatment programs in Australia consume the bulk of available Federal monies,

Australian governments have never funded treatment programs as generously as does the Canadian government. Australian Federal monies earmarked for Aboriginal drug and alcohol abuse in 1992-3 (through ATSIC) totalled A\$13 million for an Aboriginal and Torres Strait Islander population of 254,000 (1991 census) - approximately \$51 per capita. In Canada, Federal funding in the same financial year was nearly A\$54 million for its client population of 535,000 status Indians and Inuit (1991 figures) - which approximates to \$101 per capita. A large proportion of this Canadian funding goes to residential treatment centres (Brady 1995b). The up-market facilities of Poundmakers Lodge in Alberta were funded at a cost of \$6.9 million through the provincial government of Alberta - a province rich in income from oil and minerals. Aboriginal visitors to Canada frequently remark on the generosity of funding in that country and compare Australia unfavourably with this plenitude. Ample funding is interpreted as an indication of how 'serious' the Canadian government is about indigenous substance abuse problems (Wroe 1995, p.10). Even in the 1970s, the early Aboriginal visitors to Canada, Chicka Dixon and Danny Colson were both impressed with the *scale* of what was happening there. All these factors - professionalism, structured programs, quality of facilities and generous funding - can be summed up in one word: status.

The institutions of government in Australia and the structures for the distribution of Aboriginal funding also constituted mechanisms which (unintentionally) facilitated the influence brought to bear by the Canadian Indians. I have already described how historically the Aboriginal alcohol rehabilitation centres and programs developed independently - both from community-controlled health services, and from other overarching State or Aboriginal agencies. Because funding was primarily submission-based, it meant that groups could apply for grants for programs or for interventions they had (more or less) designed themselves. In the case of Alice Springs (and several other locations) in the early 1990s, the program proposals and submissions were designed by Canadian Indian consultants. Funding was available from several sources: the Commonwealth (including Aboriginal Hostels and ATSIC), the State/Territory governments, and other non-government organisations (aid organisations, church-based

agencies).<sup>59</sup> The drawback with this approach was that no single department or agency was in a position to take a calculated and overarching look at developments; it was hard for each to know what the other had funded or was intending to fund.<sup>60</sup> Nor was there any organised attempt to ensure that these programs could draw on ongoing professional expertise or information about current best practice. Crucially during the period marked by the most concentrated involvement of overseas consultants (1990-1995), one primary funding responsibility was channelled through ATSIC. At the time, ATSIC was continuing with a process of devolving decision-making within its budget to its regional councils.<sup>61</sup> This meant that the central office bureaucracy in Canberra - which had previously maintained some policy influence, had the ability to disburse discretionary funds on a nation-wide basis, and could provide some national oversight - was increasingly deprived of the responsibility for guiding financial allocations in substance abuse and other areas. This move to increase the discretion allocated to regional councils was in keeping with ATSIC's statutory responsibilities to principles of domestic self determination. By 1995, regional councils had *full delegations* to approve projects for funding that previously they had only endorsed. The 36 regional councils of elected local representatives were thus in a position to fund projects affecting their regions, without recourse to informed commentary about developments elsewhere. It is undoubtedly due to this decentralisation of decision-making that some Canadian consultants were funded and re-funded in different regions of the country, without any critical evaluation of their work being undertaken and disseminated.

---

<sup>59</sup> CAAAPU is a good example of the multiplicity of funding agencies that can be involved in Aboriginal programs. The land (at the 'Congress Farm') is owned by Congress. The temporary building construction was funded by ATSIC under the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody funding. The Northern Territory government Living with Alcohol Program and (Federal) Aboriginal Hostels funded the treatment program. ATSIC funded administration, management and training. NT Health funded the men's outreach program. The Drug Offensive (Federal) funded the women's day care and outreach program. The Federal department of Employment, Education and Training, ATSIC and Commonwealth Health funded the Train the Trainer courses (Fieldnotes September 1993).

<sup>60</sup> On the other hand, there are advantages in having multiple sources of funding in that services are protected from cuts in one area or department, and need not be tied to the performance demands of any one department.

<sup>61</sup> This is discussed in Chapter Three.

## Conclusion

As a result of all these factors discussed above, by the 1990s Aboriginal approaches to alcohol abuse simultaneously demonstrated innovation and fossilisation. It was a case of innovation without change.<sup>62</sup> There were innovative elements in terms of the reaffirmation of links with indigenous North Americans. The embryonic associations which had been forged years before, at the time when indigenous rights emerged from the civil rights movement, came to fruition. A true interchange of personnel and a cross-fertilisation of ideas occurred which gave Aboriginal health and addiction spokespeople new experiences of training and travel. The interchange with another indigenous group served to cement Aboriginal understandings of the etiology of substance abuse problems, which were seen to be associated with cultural loss, and the need for cultural regeneration. The process also enabled cultural diffusion to occur, which featured the assimilation by some Australian Aborigines of esoteric cultural practices which belonged to another (overseas) group. Healing and other rituals, such as the smoking ceremony, which were imbued with spiritual meaning in one context were incorporated, reinvented and reattributed with meaning in an Australian Aboriginal context. Above all, the links with North America reinforced the existing conviction that Aboriginal people needed to be intimately and thoroughly involved in the design and execution of programs catering to Aboriginal needs.

The developments described here also served to fossilise existing thinking among many Aboriginal treatment service providers. This meant a continuation of goals of abstinence, the use of the 12 step model and a focus on tertiary treatment approaches, to the exclusion of a consideration of earlier interventions and secondary prevention. It also excluded an exploration of alternatives to abstinence, a willingness to consider the practical features of harm minimisation, and attempts to make harm minimisation culturally recognisable. For many Aboriginal treatment providers, the Canadians legitimised what they were already doing. As is the case with the adoption or otherwise

---

<sup>62</sup> The expression was coined by Colin Tatz in a critique of the bureaucratic complexities surrounding Aboriginal health administration in the 1970s (Tatz 1972).

of research into policy, and the conditions under which ‘new’ ideas are adopted, the Canadian message was well-received because it was congruent with what they already believed (Kunitz and Levy 1995). Through the analysis of responses to the House of Representatives enquiry of 1976-77 I demonstrated how these views had become established and came to hold a preeminent position. While the indigenous treatment providers from Canada and the United States undoubtedly brought a greater emphasis on the uses of ‘culture’ in healing, they also transported with them a North American approach which ran counter to policies on substance abuse which had been established in Australia for twenty years. In the next chapter I offer a problematisation of the issues discussed so far in Chapters Two, Three and Four: interpretations and uses of culture, the polarised constructions of health, and notions of difference in dealing with alcohol problems.

## CHAPTER FIVE

---

### Contesting Difference

*A number of interconnecting themes have been raised so far. These include the rise of the 'indigenous rights' movement which argued for special rather than equal, civil rights; the impact of international bodies on conceptualisations of Aboriginal health, particularly the WHO and its broad definition of health; the development of the notion of 'difference' as it applies to Aboriginal health and the difficulties of absorbing this notion within national policies in Australia. A related theme is that of policy and service-delivery for Aboriginal alcohol problems - in which a growing emphasis on Aboriginal exceptionalism and difference came to affect policy, funding and services in this area - and the separation of Aboriginal alcohol programs from both community-controlled health services and professionals within the States. I have argued that this encouraged fossilisation, in that there was little attempt to shift the focus away from abstinence-oriented tertiary treatment. It also allowed a small group of North American alcohol advisors to have an inordinate influence on developments in Australia. One of several outcomes of the association between Aboriginal alcohol programs in Australia and the alcohol advisors and program planners from North America was an emphasis on the idea that indigenous culture itself could be a form of healing from addiction: culture as treatment. A corollary of this was a reinforcement of a separation between Aboriginal and mainstream thinking on addiction.*

*In this chapter I want to return to previous chapters of the thesis in which I examined and tracked the constructions of difference in a number of areas. These constructions of difference influenced the discourse on the special qualities of indigenous culture, identity and Aboriginality and were discussed in Chapter One. In Chapter Two I traced the development of a discourse of difference in indigenous health, in which indigenous activists harnessed the WHO's holistic definition of health on which to base their own definition, and held this up against an essentialised conceptualisation of 'Western' notions of health. Indigenous alcohol spokespeople also constructed their own definitions*

*of alcoholism, which were discussed in Chapter Four. In this chapter I examine and contest these constructions of difference, not in order to dismiss the notion of difference altogether, nor to deny the political contexts within which difference is asserted, but in order to seek out the areas in which an emphasis - or overemphasis - on difference has been unhelpful.*

## **1. Contesting the uses of cultural difference**

The emphasis on culture as a form of healing, and the stress on Aboriginality as a quality in itself, can be understood to have come about for several reasons. At its broadest level, it signified a conscious rejection of the impact of colonisation and the subsequent deleterious effects on the emotional and social well-being of the colonised. It is part of the resurgence and reclamation of indigenous identity in Australia and overseas which began in earnest in the 1970s. It can also be understood as a mechanism whereby Aboriginal people could propose alternative Aboriginal models to bring about the transformative healing that 'Western' or mainstream programs have been apparently unable to do.

### **1.1. Interpretations of 'culture'**

To begin with it needs to be stated that the term 'culture' in this discourse is increasingly used in an overly simplistic and static way. After all, as long ago as 1952 Kroeber and Kluckhohn in their famous review came up with 164 different anthropological definitions of culture (Wright 1998, p.7). Raymond Williams describes the term as one of the two or three most complicated words in the English language (Williams 1988). In many current renditions, 'culture' is equated simply with 'tradition', and in Australia the two are inevitably linked by Aboriginal people and others in the phrase 'traditional culture'. Inevitably and perhaps unintentionally, these terms hold connotations of the past, which can have the effect of straightjacketing Aboriginal people, as was the case in the colonial past, making some more 'real' than others, and burdening the rest with an essentialist position. Stephen Muecke, writing on Aboriginality and cultural studies, argues that the

totalising concept of culture has been the ‘prison’ of twentieth century Aborigines in Australia. He suggests that the legacy of our post-romantic society forces contemporary Aboriginal subjects into positions of essentialism, so that they are constantly called upon to display this ‘essence’ as if culture were an endowment. He writes:

*The avenues for this ‘being Aboriginal’ are paradoxically narrow, and they tend to be overdetermined by, precisely, ‘the cultural’. While culture is not a natural endowment, it is treated as if it is, such that the only ‘respectable’ ways for Aboriginal people to find identity in this society tend to be through particular forms of culture (Muecke 1992, p.40).*

A narrow definition of ‘culture’ runs the risk of losing the human element of choice, for people make selections from a wide range of adaptive possibilities according to their wants and needs. However, rather than being viewed as the dynamic present and future of peoples (and not just their past), culture has become a ‘thing’ that you either have, or you have lost. As Keesing (1990) suggests, culture comes to be viewed as an ‘agent’ that can *do* things. To some extent, narrow definitions of culture have come about because of a persistent stereotype - reinforced by some ethnographers - that ‘true’ culture exists only among tradition-oriented groups rather than among urbanised people; in the 1950s the term used was ‘detribalised’. Several Australian researchers see anthropology as having contributed to these views not only by suggesting, for example, that mixed-descent Aborigines have no distinctive culture, but also by neglecting to search for theoretical frameworks suitable to an explanation of culture change (Eckermann 1988; Keen 1988). Anthropologists are indeed partly responsible for promoting and valorising traditional beliefs and practices. Keesing for example, accuses anthropologists of having *invented* the tribal world of otherness, saying that we continue to overstate difference, in the search for the exotic and for the radical Otherness that Western philosophy, and Western cravings for alternatives, demand (Keesing 1990; Rosaldo 1993; Wright 1998). The very act of fieldwork encourages anthropologists to invent a culture. In its defence, it can be said that anthropology as a discipline is critically examining its earlier stance on culture. Anthropologists are now questioning what Keesing called ‘our vested disciplinary

interests in characterising exotic otherness'. While some anthropologists still maintain that there is such a thing as an authentic 'traditional' past, and that traditions can be defined, others talk about the invention and symbolic construction of culture. As Linnekin points out, cultural construction 'implies ... that tradition is a selective representation of the past, fashioned in the present, responsive to contemporary priorities and agendas, and politically instrumental' (Linnekin 1992, p.251). This view of culture as a contemporary human product rather than an inherited legacy has been part of the anthropological discourse since the 1980s. There are then, 'old' and 'new' anthropological approaches to culture, which mark a shift from essentialist meanings to meanings associated with contestation (Wright 1998, p.8). The 'old', once progressive approach, categorised and represented cultures as fixed entities, which meant that the objects of that knowledge were made the subjects of new forms of power and control. It posited a series of defined characteristics shared by apparently homogeneous individuals, who shared an underlying system of meanings: 'authentic' culture. This approach provided an archipelago view of the world, made up of 'peoples' each with a radically different 'culture', a series of discrete entities, like a string of separate islands<sup>1</sup>. The 'new' meanings of culture stress its hybrid nature, that it is a dynamic concept, always negotiable and in the process of being contested, reworked, constructed and transformed.

*Differently positioned actors, with unpredictable inventiveness, draw on, re-work and stretch in new directions the accumulated meanings of 'culture' - including old and new academic ones. In a process of claiming power and authority, all are trying to assert different definitions ... (Wright 1998, p.10).*

This shift within anthropology itself was necessary with increased cultural diffusion and globalisation. Isolated cultures no longer exist; it is hard to say where one 'culture' ends and another begins (Kymlicka 1996, p.102). The discipline could no longer operate as salvage ethnography which served the British (and other) empires, and which

---

<sup>1</sup> Wright (1998) discusses how this 'archipelago' view of cultures was provided to UNESCO as part of a trend among international agencies involved in development to make use of notions of culture.

characterised peoples as 'disappearing'. Anthropology was forced to adapt or else cease to exist in any meaningful way. It is ironic then, that indigenous as well as popular mainstream discourse seems to have adopted the 'old' anthropological objectivist notions of culture. This can be detected in numerous contexts, for example in the 'non-academic expressions of regret over disappearing lifeways and corrupted contemporary cultures' (Linnekin 1992, p.254), an emotion which Renato Rosaldo (1993) termed 'imperialist nostalgia'. The idea of culture as a 'thing' is aptly illustrated by an advertisement placed in a newspaper by an Aboriginal land council in New South Wales which featured a boomerang with the message 'Aboriginal culture. Throw it away and it won't come back'.<sup>2</sup> These essentialist notions are also prevalent in popular portrayals of indigenous cultures and their apparent spiritual, artistic and ecological holism (Burger 1990; Knudtson and Suzuki 1992; Lawlor 1991; Morgan 1991). Critics see these as cliche-ridden exercises in 'primitivism' and a usurpation of the indigenous (Cuthbert and Grossman 1996; Sackett 1991; Torgovnik 1990). Interestingly, Aboriginal responses to some of these popular 'essentialist' portrayals have been mixed rather than wholeheartedly dismissive,<sup>3</sup> perhaps because they are congenial to Aboriginal constructions of the past.

Although many Aboriginal spokespeople strenuously resist the stereotype that the only 'real' Aborigines, those who 'have' culture, are remote-living and traditionalist, it sometimes seems that by suggesting that Aboriginal culture *needs* 'preserving' or 'recapturing' (Eckermann 1988, p.32) Aboriginal people are in fact reinforcing some of the static and anachronistic meanings discussed above. As mentioned, this is partly - but not entirely - due to the influence of ethnographic work. It is also a response to contemporary political struggles. As Linnekin has observed, self conscious reflection

<sup>2</sup> *Sunday Telegraph* (New South Wales) 11 July 1993

<sup>3</sup> Hiatt(1997; Hiatt 1998) for example, draws attention to the fact that while objecting to trivial errors in Marlo Morgan's book *Mutant Message Downunder*, Aboriginal commentary remained almost totally silent on the author's fantastic assertions about Aboriginal life (that Aborigines in their pristine state communicated by telepathy, that they can heal by touch, are vegetarians, have never endangered any species, live with each other in love and peace). On the other hand, US-based anthropologist Francoise Dussart (with extensive Aboriginal fieldwork experience) provided an unambiguously critical review of the book, saying that it was a pseudo-New Age vision, 'not about spiritual matters, but about the unscrupulous commoditisation of an indigenous culture already under assault' - a book about misrepresentation, appropriation and concoction (Dussart 1994).

about one's own culture is intensified where perceived cultural or ethnic differences are politicised; ethnicity typically has its origins in relations of inequality (Comaroff 1996; Linnekin 1990). There is, for example, a need within the contemporary political and economic rationalist climate for Aboriginal people to demonstrate their uniqueness and difference in order to garner a fair share of the State's resources. 'Aboriginal culture' can now be a resource used to negotiate with the dominant society, whereas once it was considered an impediment. When Aboriginal identity and rights are perceived to be under threat from the majority culture, some form of essentialising is inevitable: Aboriginal people end up borrowing from the categories which are part of the dominant mainstream society.<sup>4</sup> Just as anthropology was forced to change because it was operating in a world very different to the one which had allowed 'mission verandah' fieldwork, indigenous peoples have reacted to globalisation and the potential swallowing up of minorities into large nation-states, by developing a discourse which reasserts their unique identities and cultures: a primordial discourse.<sup>5</sup>

## 1.2. Healing and uses of culture: some paradoxes

Perhaps because of the underlying politicisation of culture mentioned above, Aboriginal assertions of cultural difference and of the beneficial qualities said to be bestowed by cultural revival, take place largely at the level of public discourse. Conferences on substance abuse and addiction are frequently the occasions when spokespeople make the connections between cultural 'loss', revival, and the role of alcohol. However, at the grassroots level within which most people function in their daily lives, 'culture' is rarely objectified and verbalised in this way. There is a large gap between the way in which culture is talked about and the way it exists as something embedded in peoples' experiences and actions. I will analyse some of these complexities, for they have a bearing on the practicalities of substance abuse interventions which emphasise 'culture'.

<sup>4</sup> Indeed, as Kymlicka points out, it is often the majority culture which emphasises essentialist notions such as the 'purity' of minority cultures, for example by saying that only indigenous groups who have maintained an 'authentic' culture can have their land claims recognised (Kymlicka 1996, p.104).

<sup>5</sup> While he appreciates the underlying causes of the politics of identity, Comaroff (with some resignation it seems) also wonders how much longer it will be before primordialism is consigned to the 'trashheap of ideas past' (Comaroff 1996, p.164).

Alcohol and other drug abuse among indigenous people (both in Australia and elsewhere) is frequently said to be associated with the 'loss' of culture. These attributions can be useful as a heuristic device with which to explain to a wider public that substance use problems have deep and complex roots among indigenous people, but in reality the evidence is less than clear that cultural loss (or acculturation) are necessary precursors to the abuse of alcohol and other drugs. Among researchers in the United States these questions have been frankly debated. Oetting and colleagues for example, have asked why young American Indians *across* regions and cultural variations have such high drug use. They answer this question by suggesting that the *same* factors underly their drug use as any other minority population, factors such as poverty, prejudice and their accompanying effects (Oetting, Edwards, and Beauvais 1989). Rather than 'loss' of culture, they found a strong association between drug use and the peer group, especially among those young people who felt that their families did not care about them or stop them using. This increased the likelihood of Native adolescents seeking out friends who liked doing drugs. Other researchers (Beauvais and LaBoueff 1985; Beauvais and Segal 1992) agree that the same basic psychosocial processes are operating for Native and non-Native youth:

*The dynamics of drug and alcohol use are in many ways similar for Indian and non-Indian people. The different historical and cultural background of Indians, however, introduces other sources of stress but also adds strengths which would be called on for intervention programs (Beauvais and LaBoueff 1985, p.155).*

Beauvais and La Boueff agree that socioeconomic poverty and historical neglect of Indian people may provide the *background* for abuse, but suggest that 'there must be other mechanisms which account for its widespread and rapid growth on reservations' (1985, p.152). Individuals' perceptions of the 'causes' of their alcohol abuse tend *not* to stress acculturative loss or deprivation. Some ex-drinkers<sup>6</sup> have described how they drank alcohol as an act of angry resistance to discriminatory drinking laws (prior to the repeal

of prohibition) (Beckett 1965; Brady 1995a, p.162). or in reaction to a personal trauma. Interviewees also stressed Aborigines' historical unfamiliarity with alcohol, rather than their supposed loss of culture as causes of difficulties:

*Well, anangu [Aborigines] shouldn't drink! ... Because no history of the grog, the alcohol you know. Long time, so people they got tradition you know, and European culture, they got tradition too you see, wine. They drink wine in wedding. You know wedding? And very important occasion they drink. They get tradition. But anangu shouldn't drink, anangu got other tradition to look at, to look at their ways you know. (K.P)*

*No-one ever taught Aboriginal people all the wide world, no-one ever taught us what alcohol could do to our people. We just got in, just like cattle in a trough ... we go straight into the trough and have as much as we can drink. (R.H.)*

One ex-drinker when asked what he thought about the role of culture replied:

*MB: A lot of people they say Aboriginal people drink because they lost their country and their culture. What do you think about that?*

*Interviewee C.R.: No, I don't think so. I don't think so because I think they just want to drink because of what they feel about it. Like fun. And there's lot of people, thousands of people in Top End, Central Australia, that going out on alcohol, eh, even kava drinking, petrol sniffing - but still we didn't lose our culture, still got it.*

### **1.3. Cultural dilemmas in dealing with drinking**

Aboriginal treatment program managers and others intervening with alcohol users (particularly those involved with programs attempting to incorporate cultural elements)

---

<sup>6</sup> Forty-three interviews were conducted with Aboriginal and Torres Strait Islander people who had successfully given up drinking alcohol.

are confronted with some complex dilemmas around notions of Aboriginality and associated understandings of what ‘Aboriginal culture’ is. Alcohol use has become so thoroughly integrated into daily life for many Aboriginal people that ‘to drink alcohol is to *be* an Aboriginal’ (Gibson 1987); it is the abstainers who are excluded and considered ‘deviant’ (O’Connor 1984; Sansom 1980). In the US too, drinking ‘has become a valid expression of “Indianness”’ (Beauvais and LaBoueff 1985, p.158). Drinking is a valued part of the social world of Aboriginal as well as other Australians, and has become enmeshed in Aboriginal cultural mores just as in the society as a whole. In some cases, cultural meanings and actions have been transposed from other Australians. People say they ‘learned from whites … first we got shout<sup>7</sup> from whitefella … took it home to share it’ (Langton 1991, p.305). The deep-seated ‘drunken Aboriginal’ stereotype is perpetuated by non-Aboriginal and Aboriginal people alike.<sup>8</sup> As a result, programs which are culturally sensitive to Aboriginal people have a tough job in trying to stress their clients’ identification with ‘Indianness’ or ‘Aboriginality’ *and* by association, non-use of alcohol or drugs. Aboriginal individuals who attempt to give up alcohol, along with those who try to save money or get ahead, can be derided by others as trying to be like ‘gubs’ or ‘whitefella’, getting too ‘flash’, trying to be ‘different’ (Brady 1993; Keen 1988). Numerous Aboriginal ex-drinkers I interviewed (from both urban and rural backgrounds) had experienced derisive comments such as these (Brady 1995a). These responses represent levelling procedures which are reinforced through gossip, group pressure and shaming, and they are an integral part of Aboriginal social interactions and ways of doing things. They are, in a sense, embedded in Aboriginal ‘culture’. These widespread levelling devices can and do operate in ways which make it *more* difficult for individuals to extract themselves from a pattern of alcohol abuse. Aboriginal managers of alcohol programs and rehabilitation centres then, have to confront dilemmas presented by their clients’ attitudes and behaviours, which may well be in keeping with their ‘culture’ but

<sup>7</sup> A ‘shout’ is an Australian expression referring to members of a drinking group taking it in turns to buy drinks for everyone else. The larger the group, the more drinks are consumed. ‘Come on, I’ll shout you’ means simply ‘I’ll buy you a drink’.

<sup>8</sup> By saying that Aboriginal people also maintain the stereotype, I mean to take note of the ‘oppositional’ nature of some Aboriginal drinking, to which several commentators have drawn attention. It is a marker of difference, an aggressive assertion of Aboriginal mateship, contrasted with the modest drinking (or sobriety) of the middle-class European Australian or Christian (Beckett 1965; Sansom 1980).

which may facilitate, rather than disallow, the abuse of alcohol and other substances. In this case, as in many others, what is referred to as 'culture' needs to be re-worked and openly confronted; simply drawing upon it may be counter-productive to progressing treatment.

Another feature of Aboriginal life which is particularly evident in some areas of the country, and which can make grass-roots interventions difficult, is an ethic of non-interference. Customary ways of doing things, particularly in small-scale Aboriginal populations, provide strong disincentives to interfere in others' business, even if people are engaging in excessive and dysfunctional drinking which is damaging to themselves and others. People subscribe to a pervasive belief in the right of others to conduct themselves as they wish. I have described elsewhere (in the context of an analysis of the influence of social processes on petrol sniffing) how Aboriginal social life is marked by an emphasis on the autonomy of the individual - while still stressing relatedness between people (Brady 1992b, p.74):

*The acceptance of personal autonomy and the unwillingness to impose one individual's will on another exists to such an extent in Aboriginal society that individuals are, at times, allowed to harm themselves, and to disrupt the daily flow of life for others. The toleration of potentially harmful activities and the requirements of generosity as an expression of caring extend beyond childhood socialisation into adult life.*

Other researchers as well as myself, have demonstrated that the right to drink is considered incontrovertible, and it is not often subject to corporate sanction (Myers 1986; Sansom 1980). For example, in the community of 'Diamond Well' of Western Desert Pitjantjatjara speaking people (and indeed in many others), the population is composed of disparate groupings of people who are living together as a result of historical accident or circumstances beyond their control, while also being linked by language, land-holding and social organisation. Family groups and other groups which are recruited for particular purposes (eg drinking), are largely autonomous and not subject to any sanction or

jurisdiction by other groups in the community. Drinking in the community is (and has been for many years) associated with high levels of morbidity and mortality, being associated with more than 50 percent of all deaths; it is also the cause of anxiety, stress and sleeplessness, and acts as a major impediment to community cohesion and stability. Nevertheless, despite

*... a public display of concern over the issue of drinking, evidenced by the minutes of Council meetings, the members of the community subscribed to the view that drinking was a universal right. As a result of this belief they avoided committing themselves to long term or authoritarian intervention strategies on the one hand, while simultaneously instituting minor 'rules' of comportment to keep the Europeans happy, on the other (Brady and Palmer 1984, p.76).*

There is an immense tolerance of other peoples' business and ways of conducting their lives. This means that direct confrontation is difficult. As a result there is a rich variety of indirect techniques employed by people on a day-to-day basis, which do not always protect individuals or the community from harm. Neither do they always serve to diminish the intensity of consumption. Data from Canadian First Nations communities suggest that such tolerance is also prevalent there in northern regions. Savishinsky (1991, p.85) for example, writes of the firm ideals of individual autonomy and independent action in a Dene community:

*A corollary of autonomy - its negative reciprocal - was that people should avoid intervention in each other's lives ... The anti-authoritarian ethic extended to alcohol and its potential dangers ... A commitment to non-intervention makes it especially difficult for Native people to deal directly with the deviant acts engendered by alcohol.<sup>9</sup>*

---

<sup>9</sup> Among drinkers and petrol sniffers, a common reaction to expressions of concern or attempts at advice is to announce 'it's my body'. I have suggested that this *embodiment* of personal power is highly developed among Aboriginal people. The body is one object over which individuals may exert control; exerting control over others is more complex and subject to numerous social and psychological restrictions. 'It's my body' is a statement of resistance and refusal directed to others. Petrol sniffers often become anorexic and some sniffers engage in the practice in order to become thin. I have suggested that control over the

This cultural etiquette which takes the form of an extreme sensitivity to being seen to encroach on another's autonomy or to intrude in another's decision to use (and abuse) alcohol, even extends to those whose professional role should arguably include such 'intrusion' - such as Aboriginal health workers. I discuss this in Chapter Six.

Indigenous beliefs about the primacy of the immediate family often preclude effective action when it comes to the use of alcohol and other substances (such as inhalants) and I have described elsewhere instances in which close relatives undermine community-initiated interventions (Brady 1992a; Brady 1992b). Far from engaging in behaviours that would show concerted social disapproval of highly disruptive drinking activities, family members often support and protect drinkers, making allowances for their 'time out' excesses, and providing them with resources. These are, in effect, culturally appropriate 'coping mechanisms' for dealing with disruptive drinking without attempting direct dissuasion. The close relationship and kinship networks which link groups with shared language and other affiliations make it difficult or impossible to prevent illegal grog-runners from entering communities, or to oust unwanted individuals. Drinking groups often demonstrate a 'culture' of togetherness and solidarity, as do those who feel themselves to be marginal or excluded (for example those people who live in what used to be called the 'fringe-camps', and are now called the 'town camps' of Alice Springs) also helps to sustain the role of alcohol in their lives. The solidarity brought about by shared oppression among these individuals helps to fend off external threats to their way of life, but simultaneously maintains excessive, damaging drinking as a normal feature, as O'Connor (1984) and Beckett (1965) have pointed out. Ironically, Aboriginal people who become sober are often forced to leave their communities and begin a new life in a town, or interstate, in order to avoid the intense social pressures to continue in a particular style of drinking and where they may have *less* contact with so-called 'cultural' activities. Comments from ex-drinkers revealed the necessity of this separation: 'I didn't mix with them, I just gave them the biggest room, I didn't want to be any part of them.'

---

ingestion of food (usually by teenage petrol sniffers) constitutes the ultimate and remaining expression of control available to otherwise powerless young Aborigines (Brady 1992b, p.75-82).

No good, once your mate is there, he'll tempt you for sure' (Brady 1995a, p.105). Individuals who do abandon drinking and manage to obtain employment and housing either within their home settlements, or in the nearest town, frequently become the focus of drinking relatives who know they may obtain food and shelter there. As one man from Yalata community once said 'I can't lock my door against them'. Other researchers have noted that many Aboriginal people struggling to deal with their alcohol or drug use, found that their communities were of no help, or were of minimal help in this struggle. More than half the Aboriginal clients of treatment programs questioned by Alati thought that their culture either did not help them at all, or only helped them a little. Sixty-one percent thought that spirituality was of little help either (Alati 1996, p.63).

A further dilemma in institutionalising cultural practices or cultural identity as a symbolic device in healing (or for any other purpose) is that it requires a 'smoothing' of intra-Aboriginal cultural diversity and an emphasis on the essential oneness of all people of Aboriginal descent (Tonkinson 1990).<sup>10</sup> Aboriginal people have long been forced to contest the supposed homogenisation of their societies - for this is how they have been depicted historically in non-Aboriginal commentaries and in government policy - and yet introducing something called 'culture' into treatment requires a degree of homogenisation.<sup>11</sup> In Canada this smoothing out of local variation has taken place through the widespread introduction of practices and approaches which may be specific to particular regions. The sweat lodge, introduced in prisons and treatment centres across Canada is an example of this pan-Indianisation (Hall 1986) despite the fact that this form of ritual purification and healing was never evenly spread across regions.<sup>12</sup> The cultural activities of Poundmakers Lodge and the Nechi Institute in Alberta, and which have

<sup>10</sup> As a result of the size of Australia, and the dispersal of populations in it there was no homogenous Aboriginal 'nation' prior to European occupation; hundreds of distinct groups lived in Australia, in widely differing ecological zones and with their own languages.

<sup>11</sup> This is epitomised in the Nechi Institute Training Information Package from Canada which informs its clients that at the end of the course, participants will (among other things) be able to: Define culture and tradition; explore what a traditional sweat is; and explore the concept of healing and healers.

<sup>12</sup> Interestingly, sweat or steam baths are also used in the rehabilitation of drug addicts in Malaysia and Thailand (Heggenhougen 1984; Poshyachinda 1993). One treatment centre in Canada introduced the sweat lodge in a region (the far north-west) where it was not traditionally practised. As a result the lodge fell into disuse. A morning sweetgrass ceremony there, more characteristic of central and eastern ceremonial practice, was more popular among staff members than clients (Anderson 1992).

become ubiquitous, are based on Cree and Plains Indian practices which are alien to other linguistic and cultural groups such as the Inuit, Labrador Innu, and coastal peoples of the north-west. The cultural and 'traditional' component of these programs has also been criticised as being superficial and merely grafted onto an Anglo-American model (Saggers and Gray, 1998, p.148; cf p.151-153). Kunitz and Levy (Kunitz and Levy 1994, p.209) suggest that 'traditional' rituals have now become part of a folk system in the United States. In Australia, some difficulties were encountered by CAAAPU in its attempt to Aboriginalise its program in Alice Springs: some clients complained that there was not enough Aboriginal culture in the program, and others that the program ignored local cultural sensitivities by allowing men and women to mix, and by failing to pay attention to linguistic variation and other language difficulties (Rowse 1996). In New Zealand, where an initiative is underway to develop Maori drug and alcohol treatment programs offering 'cultural linkage', implementation has been difficult because there are no instruments available to monitor the cultural linkage process, and the process itself has not been described with any degree of precision. In addition, there is only anecdotal information to suggest that cultural factors are important in the optimal treatment of Maori with alcohol problems (Sellman et al. 1997; Westermeyer 1981).

Another issue that requires attention is the unhelpful vagueness of much of the discourse around cultural and spiritual aspects of treatment and 'healing' from addiction which makes these potentially important elements of Aboriginal programs vulnerable to New Age appropriation and the predations of fringe practitioners.<sup>13</sup> While some attempts to fuse elements of Aboriginal spirituality and culture with New Age (and other, such as Jungian) teachings are well-meaning and some may have beneficial outcomes, what is

---

<sup>13</sup> Lawlor (1991) for example attempts to link New Age notions of magnetic fields with Aboriginal dreamings. An Aboriginal woman of the 'Black Cockatoo totem' advertises herself as a therapist in Canberra using the 'ancient rituals of the smoking ceremony, hands on healing, massage, crystals and the traditional way of Respectful Listening' (pamphlet for 'Beyond Belief'). In Alice Springs the non-Aboriginal proponents of the 'Sugarman' project (a Jungian-based dance-drama of the Dionisos myth and the origins of intoxication) stated that while cognitive, rational and AA approaches to substance abuse had their place, 'there is a place for the dramatic poetic imagery of the teaching story, and the ceremonial, a form which, after all has served as the basis for the teaching communications of religious and philosophical traditions in all cultures, immemorial' (cf. 'Finding ashes of a burnt out mother' *Alice Springs News* 24 September 1997:11) (San Roque 1995-6) Cuthbert and Grossmann (1996) suggest that these are 'nativist discourses' - an indication of the continued Western infatuation with the primitive.

notable about these approaches is their ‘strenuous non-specificity’. New Age teachings have a ‘universalising rhetoric’ (Cuthbert and Grossman 1996, p.30) in which indigenous cultures worldwide and within Australia are lumped together in a process which equates with the homogenisation to which so many Aboriginal people have objected. Many (especially people with an urban background) are sympathetic to these alternative perspectives,<sup>14</sup> but others are looking for more practical help with their substance abuse problems. For example, a Koori speed user questioned by Alati observed that, ‘you can't talk spirituality to drug addicts. We are too cynical. Rationality. That's what we need, rationality’. She found that practical counselling on relapse triggers was helpful (Alati 1996, p.96).<sup>15</sup> It may be that one of the unintended consequences of emphasising the need for more ‘cultural’ or spiritual models for use with Aboriginal clients of treatment programs, is that such an emphasis implies that conventional therapeutic or advice models are *inherently* ethnocentric and inappropriate - when this is not necessarily the case (Wiebel-Orlando 1987).

## 2. Contesting difference in constructions of health

In Chapter Two, I demonstrated that in the context of the struggle to create and maintain separate, culturally sensitive and community controlled health services, Aboriginal health advocates elaborated the WHO definition of health (a state of complete physical, mental and social wellbeing, not merely the absence of disease), invented their own definition(s) of what ‘health’ means, and pitted these against their portrayal of a ‘Western’ model. Since that time the perception has grown among government policy-makers, agencies, program planners and deliverers that Aboriginal people indeed must hold entirely alien

<sup>14</sup> For example, an advertisement for Dreaming Workshops reads: ‘Are you looking for a doorway into a world that time forgot? Interested in dispersing cultural barriers through healing and dreams? There are a growing number of Aboriginal mentors who are very loving and forgiving in their attitude to Westerners. Two such people are currently making it known the door is wide open to the Aboriginal spiritual tradition. All that is required is an attitude of humility and respect for the way... The journey in healing is made through Kurunpa (life-force, spiritual energy), learning ways to balance depletions and invasions as well as how to build up your Kurunpa...Contact Tjapaljari Seminars, PO Box 57 Hazelbrook NSW 2770’.

<sup>15</sup> In his denouement of the rise of spiritualism in Britain and the US, Washington (1995) notes the rarity of ‘practicality’ in the teachings of mystics, spiritualists and theosophists. He singles out the teachings of Rudolph Steiner as being an exception, for he found a way of putting his theories of a spiritual and biological eco-system into practice, setting up educational, therapeutic and medical enterprises.

and different understandings of health and illness. In recent years this has contributed to an unhelpful hesitance in taking on Aboriginal health problems: a paralysis wrought by cultural sensitivity.

In the process of demonstrating difference as part of the struggle for resources, it was necessary for Aboriginal health activists to side-step issues which would confound the progress of the ideological struggle and the rationale for separate funding. One of these confounding issues is that 'Western' models of health are both more holistic and more sympathetic to notions of wellbeing than they are given credit for.

## **2.1. Polarised models of health: Western bio-medicine**

In indigenous health discourse, the West is portrayed as the bearer of a hegemonic, egocentric and solely bio-medical model of health as opposed to other, more 'holistic', sociocentric and harmonious societies<sup>16</sup>. As Payer (1989) suggests in her book on medical cultures in the US, France, England and Germany, such views reveal widespread ignorance of the diversity of medical traditions in developed countries and indeed that these medical traditions are both more heterogeneous and contested than is allowed for in these accounts. In reality, since the 17th and 18th centuries, there has been in the West a historical acceptance of the relationship between affective and physical states, and the influence of the mind on illness. Even Louis Pasteur suggested that the psychological state could influence resistance to microbes. 'Morale' and the psyche are now thought of more than ever in connection with organic disease (Herzlich and Pierret 1986). The land itself, its spiritual ambience as well as its medicinal flora - frequently referred to as being peculiar to indigenous or native beliefs about healing - also has a place in Western notions of healing. The survival of early 'Western' views of the influence of environment on health is seen in names such as *malaria* (from the Italian for 'bad air'). Whether or not

---

<sup>16</sup> As Williams points out, the term 'Western' has lost its geographical reference and become a political and social term (Williams 1988). Nathan and Japanangka (Nathan and Japanangka 1983, p.88) see the basis of Western medicine as follows: 'It is the opinion of the "experts" which defines and controls health and illness today. Illness is perceived as the malfunctioning of a mechanical system, the body, and this perception is object-oriented, not person-oriented. Treatment consists of surgical and chemical intervention administered by the specialists, who are representatives of the ruling classes.'

they are a legacy of romanticism, the wildness of nature, long walks, hydrotherapy, fasting, herbal medicine, spas, Rudolf Steiner's notions of 'balance' are all accommodated as healing strategies to varying degrees, particularly in Europe.

There are two outstanding examples (maybe more) of Western healing techniques which draw on notions of natural substances, climate, landscape and the mind, which are still in use, and which are thoroughly integrated into formal European health care systems. These are *das Heil- und Kurbad* (the healing and curing bath) in Germany, and homeopathy in England. Germany has a highly refined system of spas for water cures (and even air-cures *Luftkurorte*) which date from Roman times and were particularly fashionable in the 19th century. This movement was and is institutionalised, with involved scientists and doctors forming a Balneological Society in 1878 in Berlin. A *Bad* must be officially designated, checks of water quality and efficacy are made, and treatments can include variations of hydrotherapeutic bathing and water treatments (such as 'Kneipping'<sup>17</sup>) as well as drinking the waters (in prescribed amounts and from prescribed locations). A stay at a *Bad* is generally for preventive or convalescent purposes (for example after an operation), or for dealing with specific phases of illness, for periods of four to six weeks, in which the natural substances of earth, water, climate and landscape are seen to provide a 'stimulus- reaction treatment'. These rehabilitative healing centres were once free, but as a result of cuts, patients now contribute around DM 25 per day, while the remaining 90 percent of the considerable costs of accommodation and treatment is covered by health insurance.<sup>18</sup>

Homeopathy,<sup>19</sup> based on the principle that 'like cures like', dates from the 18th century, and was legitimised in the late 19th and early 20th century by the founding of five homeopathic hospitals in Britain. While it has never been a serious rival to orthodox

<sup>17</sup> Named after Sebastian Kneipp, a 19th century preacher who invented a therapy using alternating warm and cold showers, and walking in shallow water (known as 'Kneipping') (Payer 1989). Kneipp lives on in the form of lotions and herbal bathing products which can be purchased in German pharmacies today.

<sup>18</sup> I am indebted to Dr Britte Duelke, Frankfurt University who provided this background information, drawing on and translating from *Die Kur in Deutschland* by Deutscher Baederverband (ed) (1998) Bonn.

<sup>19</sup> Homeopathy was founded by a Leipzig doctor who became disillusioned with the cruel and ineffective treatments of the time (1790). Its use is now widespread in India, in parts of Europe particularly France and Germany, and South America (Castro 1990; Porter 1999).

medicine, homeopathy is *still practised* under the National Health Service, the hospitals still function, and interest in it - as well as other forms of 'complementary medicine' - has been undergoing a renaissance since around 1970 (Castro 1990; MacLachlan 1997; Porter 1999; Vyse 1997). Both these cases, *das Heil und Kurbad* and homeopathy, demonstrate that in contemporary Western countries a holistic conceptualisation of health is legitimised, institutionalised and integrated. By 1981 in the UK, the number of complementary medicine practitioners (including those with medical qualifications) was *higher* than the total number of general practitioners (Porter 1999, p.688). Also in the UK, two out of five general practitioners now refer patients to complementary therapists. So, one might ask, where in all this is the hegemonic 'Western' bio-medical, anti-holistic model of health? As Kleinman points out, each health system (including that of 'the West') is structured into folk, popular and professional sectors which allow for informal self-help, family advice, and non-bureaucratic avenues (including sacred and secular healers, complementary medicine) to be pursued (MacLachlan 1997, p.232).

In France, the notion of *terrain* (loosely translated as 'constitution') influences diagnoses of illness and results in less aggressive use of drugs in treatment. It allows for regimes such as rest and stays at spas as a means of shoring up the individual's immune system. Western models of health also include Polgar's 'elastic' view that health is an accumulated resistance to potential dangers, and also the view that health is a process of balance between the individual and his environment (Lewis 1986). George Engel (1977) the proponent of the biopsychosocial model, points out that the dichotomy between 'disease' and 'problems of living' is by no means a sharp one. Engel suggests that individuals decide whether they have a problem of living or whether they are sick, and that these boundaries are unclear for the patient and for the doctor. He says grief, for example, is a borderline condition, and asks if grief is a disease, and if so, when is it a disease? Engel draws attention to ordinary individuals' assessment of their levels of ease and functioning as being part of their perception of health, as does Geoffrey Rose who points out that 'doctors tend to give the highest priority to the prevention of death and acute illness, whereas members of the public may attach more importance to how they feel and to impairments of daily living' (Rose 1994, p.10). Data on peoples' subjective

perception of their health status juxtaposed with an objective measure such as life expectancy, provide evidence that it is quite common for lay members of the public *in any society* to attach more importance to how they feel and whether they can function in their daily lives, than the ‘real’ medical picture shows, and yet this is another feature of health perception that is claimed to be the prerogative of Aboriginal people. ‘It would be difficult from the Aboriginal perception to conceptualise “health” as one aspect of life’, states the National Aboriginal Health Strategy. ‘In contemporary terms Aboriginal people are more concerned about the ‘quality of life’ (National Aboriginal Health Strategy Working Party 1989, p.ix).

As I have argued elsewhere (Brady, Kunitz, and Nash 1997), the broad WHO definition of health which is so often said to be incongruent with ‘Western’ medical traditions and closer to indigenous ones, is itself firmly *part of* a Western history in which there is a belief that progress in health can be scientifically directed, that health and disease have multiple rather than unitary causes, and that they are intricately connected with social and political inequality. The original 1948 WHO definition of health – ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ - with its ‘ringing and idealistic tones’ (Porter 1999, p.485), was drafted by a Technical Preparatory Committee selected because of the expertise of its members. It is likely that the man largely responsible for the broad definition of health was a Professor at the University of Zagreb, in what used to be Yugoslavia, Dr Andrija Stampar. Health for All was announced in 1978, with primary health care as the means of delivering it, and like many such events it was ‘less a birth than an endorsement of an idea whose time, by popular consensus, had come’(Mull 1990, p.29). It has become clear in the intervening years that ‘total health’, the idealistic state of complete physical, mental and social wellbeing is turning out to be a more and more tenuous goal. While physical well-being has improved in the developing nations, there has been a deterioration in mental health. As people live longer, they become more dissatisfied with medicine and health care (Kleinman and Cohen 1997; Warren 1996). In the years since 1978 there has been a high level of activity in the developing study of the social determinants of health. These are concerned not just with the effects of poverty on health and access to health care, but

with more subtle and elusive concepts such as ‘sense of destiny’ and control, the impact of low social status and feelings of shame, humiliation and being disrespected on health, social cohesion and mortality (Evans, Barer, and Marmor 1994; Marmot 1997; Royal Australasian College of Physicians n.d.). These developments provide further demonstration of the wide-ranging scope of ‘Western’ conceptualisations of what health means.

## **2.2. Polarised models of health: indigenous definitions**

I described in Chapter Two the circumstances under which the first Aboriginal definition of health was invented, and the underlying reason for its formulation. The original definition of ‘health is life’ was created with the specific aim of contributing to a policy-making exercise by the Northern Territory Health department. First articulated at a government-initiated policy meeting in Darwin by Gaitjil Djerkurra, a Yolngu-speaking man from Yirrkala, the idea that there was no word ‘health’ in Aboriginal languages, was rapidly disseminated. Ultimately, the supposed lack of a word became part of the rationale for subsequent pan-Aboriginal holistic constructions of health

Just as selective representations of a supposedly monolithic Western health model are at variance with the more subtle reality, it also seems to be the case that by encapsulating indigenous understandings into brief glosses (‘the Aboriginal/Maori definitions of health’), these ways of thinking about health and illness run the risk of becoming crudely attenuated. Gaitjil Djerkurra was in fact struggling to articulate the fact that Aboriginal languages contain *multiple* polysemic meanings which are used to describe healthiness. Notwithstanding this, the absence of a singular term and the ‘official’ Aboriginal definition of health based on Djerkurra’s original 1981 phraseology, was canonised in the 1986 National Aboriginal Health Strategy as being ‘a whole of life view’ which includes the cyclical concept of ‘life-death-life’. Turning, ironically, to the West and the WHO, it was said to be: ‘not just the physical well-being of the individual, but the social, emotional and cultural well-being of the whole community’.

Linguists have contested the now conventional wisdom that Aborigines have no ‘word for health’.<sup>20</sup> Father Peile, a linguist and Pallotine father living at Balgo, Western Australia, is one of these. He wrote a detailed linguistic ethnography about Kukatja conceptualisations of the body and of health, and observed that writers who report that Aborigines do not have equivalent terms for ‘health’ and ‘healthy’,

*...ignore the way that Aborigines express such abstract concepts. They extend the core meaning of a lexeme to include functional and symbolic meanings. For example the Kukatja extend the meaning of langa (ear) to include ‘hearing’; paniya (eye) includes ‘sight’. The symbolic meanings of miparrpa (face) include ‘appearance’, ‘person’, ‘personality’.* (Peile 1987, 34.2.1.; Peile 1997)

So the explanation for this apparent lacuna in the language is associated with polysemy (multiple meaning) rather than with the ostensible lack of a term and as a corollary, a lack of understanding of what health means. It is common in many languages for the meaning of a single word to consist of several related senses, that is, to be polysemic. Another aspect of this is that one word can refer to an entity, but also point to its potential presence - so that one word can mean both ‘game animal’ and ‘meat’ and another covers both ‘firewood’ and ‘fire’. A word can refer to a concrete entity and also its abstraction - so that the word for ‘fire’ also means ‘heat’. Fleming and Devanesen referred to the ‘Yuendumu Wankaru Centre’ (for Yuendumu Health Centre) in their exegesis on the 1981 meeting at which the definition of health was arrived at.<sup>21</sup> *Wankaru* is indeed a good example of polysemy; the dictionary entries include ‘alive’, ‘healthy’, ‘health’, ‘life’, and a number of other inter-related senses (Brady, Kunitz, and Nash 1997). This means that people may *have a concept* without having a specific word identifying that concept. Just because there is no single word does not preclude the abstract conception of health as a state independent of its context - any more than the absence of a Warlpiri word meaning ‘sight’ indicates that there is no conception of vision apart from the eyes. The apparent

<sup>20</sup> I am indebted to the linguist David Nash for some of this commentary.

<sup>21</sup> The Yuendumu health clinic now has a sign on the door reading : ‘yantarnili ngurrjumaninjakul/ Yuendumu Health Clinic’ (which means: ‘come here to get better’). Thanks to David Nash for this observation in 1995.

non-existence of a ‘word for health’ then, is a consequence of the *structural features of Aboriginal languages*, not necessarily the result of Aborigines having entirely different perceptions of health to those of people with European origins.<sup>22</sup>

It is noteworthy that many official representations of what are said to be Aboriginal understandings and definitions of health, emphasise cultural differences and point out their exotic and supernatural features rather than natural and prosaic ones. An extreme example of this is found in a book on Aboriginal health (co-authored by a Central Australian Aboriginal man and a European researcher), which implies that, as a result of their other-worldly qualities, Aboriginal people do not really feel pain:

*Indigenous medicine confronted pain, impairment and death directly, for these things were conceived of as natural or metaphysical evils. Suffering was built into everyday life and peoples' behaviour reflected the conviction that reality was harsh, illness the result of transgression, and death was inevitable. The meaning of pain was cosmic and mythic, a corruption in nature or social organisation, and interpreted as part of the ontological totality of existence. Pain was made tolerable, for the cultural setting provided the paradigms and myths which enabled pain to be expected and perceived as a challenge (Nathan and Japanangka 1983, p.91).<sup>23</sup>*

By way of contrast with reified accounts such as this, it appears that Aboriginal understandings of health and illness are expressed in a rich variety of ways across the country, and ranging from the prosaic to the esoteric. Perhaps the most detailed investigation into Aboriginal understandings of the interrelationship between health, body and spirit was that undertaken by Father Peile among Kukatja speakers at Balgo. He

---

<sup>22</sup> Hilaire Valiquette (1993) provides 37 different terms used for health in his index to Kukatja.

<sup>23</sup> Could it have been that the authors had been reading the work of Ivan Illich who was popular at the time? He wrote: ‘Modern cosmopolitan medical civilization denies the need for man’s acceptance of pain, sickness and death. Medicinal civilization is planned and organised to kill pain, to eliminate sickness, and to struggle against death ... Traditional culture derives its hygienic function precisely from its ability to equip the individual to make pain tolerable, sickness understandable, and the life-long encounter with death meaningful’(Illich 1975, p.90).

criticised the suggestion that health for Aborigines is a ‘state of harmony’ between all animate and inanimate beings. He found that people living at Balgo hold two basic concepts of health: the body being cold and dry, and the spirit residing in the navel and stomach. He demonstrates that there is a strong relationship between health and the spirit, and health and a (hunted) meat diet. Meat and blood feature strongly in conceptualisations of health. The spirit or *kurrunpa* is a term used for the invisible principle of life, but also for physiological manifestations such as the activity of the heart, throat, lungs, diaphragm and pulse. The spirit is equated with the stomach, so that people place their hands on the stomach to indicate mental pain or anguish. He offers detailed phrases in Kukatja which are indicators of health: having a ‘strong’, ‘hard’ head; having a ‘good nose’ (for sensing); having ‘good breathing’; having a ‘good spirit’ which is lodged in the stomach region. His exegesis of Kukatja conceptualisations continually stressed that health is derived from blood, for blood is life, and the source of this life is primarily meat (Valiquette 1993; Wiminydji and Peile 1978).<sup>24</sup> He elicited a long text in language from an elderly man, which included the following passage:

*Meat always keeps my brain cold. Without it my head would get a headache, so I go out, kill an animal and eat it ... [a young man] feeds himself with meat, he gives himself blood, he gives himself spirit, he eats the meat together with the fat. He feeds himself with fat ... Without meat the heart and the soul become dry. Blood gives breath to the heart when a person eats meat. Meat gives blood, meat gives breath to the skull, it gives it to the ears, to the hands, everywhere there is blood from meat. I won't live if I do not eat meat, if I don't kill and eat blood. ... We kill animals and eat the blood, otherwise we would die. We breathe that we may exist, breathing and existing come from having meat (Wiminydji and Peile 1978, p.500-501).*

<sup>24</sup> There is indeed an emphasis on meat-consumption among desert people. The work on diet and lifestyle I undertook with colleagues on the Maralinga Lands provided extraordinarily high figures on meat consumption among Pitjantjatjara people. We found a per capita daily intake of meat (including bush meat, tinned, frozen or fresh store meat) to be nearly 907 grams. Of this, bush (hunted) meat comprised 600 grams. These figures were higher than any others among hunter-gatherers we could find to refer to (Palmer and Brady 1991).

Peile encouraged health staff to explain that a particular medicine would make people 'cold' and 'dry' rather than endlessly urging people to be 'healthy'. In this way Peile believed that there was scope for syncretism and integration between traditional Kukatja beliefs and Western systems, and that medical personnel should inform themselves of local health-related beliefs.

There is no doubt that in many areas certain symptoms are associated with spiritual or ritual matters and must be treated accordingly. There may not always be clear distinctions made between the natural and the supernatural, although Aboriginal people living near Darwin, and on Groote Eylandt, distinguish between life-threatening 'dangerous' sickness (possibly associated with sorcery), and simply being 'crook' (Sansom 1988; Scarlett, White, and Reid 1982; Webber, Reid, and Lalara 1975). Beliefs about the causes of *sudden* illness and death are usually associated with sorcery or with sites on the land, and such beliefs are prevalent in parts of Central and northern Australia. Sorcery involves ill-intent which must be analysed and resolved socially (Cawte 1996; Reid 1983). The land contains dangerous sites which can provoke sickness and death if they are misused (Biernoff 1978), and damage to other categories of sacred places can result in physical symptoms being experienced by individuals with special connections to those locations. In other words, individuals can become 'unhealthy' because of something untoward happening to their land (Downing 1988).<sup>25</sup> Under these circumstances, health is understood to be restored only by traditional healers. Soong (Soong 1983) documents the use of traditional healers (*margidjbu*) at Oenpelli for symptoms associated with sorcery, and these specialists also treated people for a variety of illnesses (chest trouble, broken bones, TB). Reid (1983) documented the work of the healers (*marrnggitj*) at Yirrkala, and interviewed 43 Yolngu in depth about their views on causes of illness. She found that between one quarter and one half attributed serious problems such as pneumonia, psychiatric illness, leprosy and heart attack to sorcery or the transgression of sacred laws (Bell 1982; Elkin 1977; Reid 1978; Reid 1983). At Yalata in South Australia, where there

<sup>25</sup> I experienced this connection in 1982 when visiting a site in the Great Victoria Desert; the site which was associated with a mythological willy-wagtail woman had been damaged by the blows of an axe. This in turn 'caused' an elderly Pitjantjatjara woman who had been born at the site and was known by the same name, to suffer from severe back problems, an association which was well-known in the community.

were no resident traditional healers (*ngankari*), those with ailments associated with spiritual or ritual matters travelled long distances to seek treatment from *ngankari* at Indulkana to the north.<sup>26</sup>

*Social harmony* is stressed by Aborigines and ethnographers alike as being an integral part of health and well-being for indigenous people. Hamilton (1982) found that for the Yankunytjatjara in northern South Australia, health was the outcome of good feelings associated with the social harmony achieved when people observed appropriate social relationships and ritual obligations. The movement of people in Central and Northern Australia to decentralised settlements (the homelands movement) has improved well-being according to anecdotal (Downing 1988) and empirical research (McDermott et al. 1998; Morice 1976) and this improvement is undoubtedly related to an easing of stress in both environmental and social/familial contexts among other things. Writing of Koories in Victoria, Anderson stated that well-being is as much to do with family relationships as with experiences of the physical body (Anderson 1994a; Anderson 1994b). Social harmony is so important that it is often given a much higher priority than physical discomfort or illness, to the extent that many health maintenance activities (such as keeping to a special diet, conserving food supplies, maintaining hygiene) are compromised by the social compulsions of generosity, demand sharing and non-authoritarian dealings with other people. Social and familial factors can have an immense impact on health, as documented by Anderson with respect to diabetes management, and by Devitt and McMasters (Devitt and McMasters 1998a; Devitt and McMasters 1998b) in a study of chronic kidney disease. Some kidney patients choose to return to the social milieu of their families, thus hastening their deaths, rather than prolonging their lives by remaining isolated in town on dialysis treatment.

The tendency to *overemphasise* the supernatural in Aboriginal conceptualisations of health and in attributions of illness - a preoccupation which seems to have gathered pace

---

<sup>26</sup> My fieldnotes from 1982 document some of these instances. In one case, a woman inadvertently touched a container of secret ritual objects and experienced a swelling in her arm as a result. In another, a man whom I knew suffered from psychiatric illness told me that he was cured when a *ngankari* from Indulkana extracted heavy objects from his body.

in recent years - belies some surprisingly prosaic Aboriginal health perceptions which have been documented by fieldworkers. In the mid-1970s, Aboriginal people participating in the early Aboriginal Health Worker training program in Central Australia were asked to conceptualise what they thought of as 'health' into paintings. Dr Devanesen, at the time the District Medical Officer, was given a drawing showing a family, water source, food, a hearth and shelter, using the symbolic representations now widely recognised in the acrylic paintings on canvas of Central Australia (Devanesen 1978).<sup>27</sup> Pitjantjatjara speakers, as well as other language groups, conceive of good health as being associated with plumpness or fatness. The Western Desert term *kaynpi* used by Yalata people, means both 'fat' (including the fat surrounding animals' internal organs) and 'good' or 'well'. 'To glow with health is to be as one who is covered with fat' (Bell 1982, p.209).<sup>28</sup> Webber (a psychologist), working on Groote Eylandt in the mid 1970s concluded that other than those illnesses interpreted as being of a mental or spiritual nature (which were perceived to be caused by the ill-intent of others), people 'have an idea of good health and injury similar to that found in European society' (Webber, Reid, and Lalara 1975). Janice Reid (1983) who undertook long-term ethnographic fieldwork in Yirrkala, found that a social or spiritual cause for illness was not sought until the illness became serious, or the patient had died. The origins of the great majority of illnesses were ignored or said to be the result of 'natural' causes.

There is widespread indigenous recognition of natural causes for ill-health (Scarlett, White, and Reid 1982). Beliefs that diet, dust and weather influence how well people are, together with the existence of a detailed lexicon of anatomical terms, are inconsistent with the view that Aboriginal medicine focused only on the supernatural. Most people in Yirrkala who become ill are treated at home or at the health centre 'with little fuss or thought about the cause', and are expected to bear small complaints with stoicism (Reid 1983, p.92; Sansom 1988). Wik-Mungkan people on Cape York recognise simple somatic illness as well as psychosomatic and sociosomatic illnesses (McKnight 1982).

<sup>27</sup> This was undoubtedly a precursor to the 'health is life' strategy promoted by the Northern Territory Department of Health from 1981, which was launched after the meeting between Aborigines and health officials at which Gaitjil Djerkurra's definition of health was conceived and adopted.

Further evidence that ill-health is not always associated with spiritual causes lies in the wealth of Aboriginal folk knowledge and use of home-based remedies. Among Western Desert people, these range from smearing the body with fat (usually butter these days) and lying between fires to sweat out a cold, to collecting and making 'bush medicines' from natural flora. Knowledge of many of these remedies is generalised rather than specialised. Health promotion was understood by Western Desert people with whom I worked; they nominated several health-promoting substances: the juices of the large goanna *Varanus gouldii*, the blood of red kangaroo, the rubbing on of porcupine (echidna) fat; and holding babies over specially prepared smoke.<sup>29</sup> Living on or visiting their own land is also seen as being a form of 'health promotion' by people with whom I have worked, and this belief in the redemptive and healthful properties of the land is why it is so often suggested that petrol sniffers and those with alcohol problems should 'go bush'.

Victorian Koories using an urban Aboriginal health service who were asked how they would describe a healthy person noted the following attributes: bright eyes and shiny hair, someone who doesn't look tired, height and weight is balanced, looks fit, eats well, clean, tidy, regular meals, a person who is cheerful, got a lot of get up and go, active, no worries, looks after themselves, who is vibrant, active, laughs a lot and has bright eyes (Nathan 1980, p.50). Johnson (Johnson 1993, p.27) asked people living on the remote Mornington Island, 'who is the healthiest type of person?' and was told:

*Initiated men [are the healthiest type of people]. They are proud strong people. They have clean houses. They have a good diet, fat, fish, fruit, meat, bread. They walk around a lot hunting and fishing. Maybe they drink a little bit but they look after their family, go to church.*

---

<sup>28</sup> Similar links between 'good' and 'fat' were noted by Jeannie Devitt at Utopia in Central Australia (Pers.comm).

<sup>29</sup> These data emanate from work I undertook as part of the Maralinga clean-up studies by the Technical Assessment Group; some are reported in Palmer and Brady (1991).

It is unlikely that any ‘Western’ medical practitioner (even the most bio-medical of specialists) would disagree with these depictions of a healthy person.<sup>30</sup>

### 2.3. Conscious constructions of health

I have shown that both Western and Aboriginal conceptualisations of health are complex - more complex than one would imagine judging by the glosses produced over the last few years. Bio-medicine, reductionism and specialisation have undoubtedly been the dominant - but not the sole - themes in Western medical traditions. Aboriginal conceptualisations of the elements which go to make up ‘health’, and those that induce illness and discomfort, include the everyday as well as those associated with social relationships, spirituality, sorcery, and relationships with land.

Idealised models of health have been formulated and invented by the ‘West’ (as we see in the WHO definition and ‘Health for All’), and by indigenous peoples (the Maori and Aboriginal definitions of health). Each was created in order to precipitate an advancement in policy thinking and action, and as a means of redirecting both focus and funding. The wording of the preamble to the WHO constitution in 1948 and the Alma Ata Declaration definition in 1978 were part of a growing reorientation of thinking on health care towards a sociological and participatory perspective which recognised the right of all peoples to good health. This reorientation had been underway since at least the late 19th century, was developed further as ‘social medicine’ in the early 20th century, and now forms the basis of a new direction in understanding health inequalities and the multiple determinants of health at the end of the 20th century.

In New Zealand, the Maori definitions were invented and documented at a series of meetings consciously designed to create them. The definitions emerged at a time (the late 1970s) when both Maori and other sections of the population were concerned about the

---

<sup>30</sup> These Aboriginal descriptions of health are comparable to that suggested by David Werner, the author of the classic handbook of primary health care *Where There Is No Doctor*. He said ‘Health is more than not being sick. It is well-being, in body, mind and community. People live best in healthy surroundings, in a place where they can trust each other and work together to meet daily needs’(Werner 1993).

overemphasis on biological and physical aspects of health and the perception that many doctors had become narrow in their focus, excluding ecological and caring dimensions (Durie 1994). The four Maori dimensions of health were portrayed as a set of interacting variables not dissimilar from the WHO definition, although they differed from it by being 'firmly anchored on a spiritual rather than a somatic base' (Durie 1994, p.71). The Maori definitions were specifically aimed at providing a framework which would enable there to be a semblance of Maori ownership over health (just as the Aboriginal one was in the Northern Territory). The Maori input to health policy has indeed borne fruit in New Zealand, and has had an impact on New Zealand health services generally. The Board of Health advocated a national health policy which would include the principles of holism, empowerment, social and cultural determination, equity of access and devolution, and equitable and effective resource use (Durie 1994, p.79). According to Durie, the Maori definition also had the desired effect of giving Maori the confidence to reclaim a more active participatory role within the health sector.

In Australia, the creation and uses of the original Aboriginal definition of health also had its birth at a specially-convened meeting, and has achieved considerable political currency. Ironically this was the case for two opposed groups, the Northern Territory government and the community-controlled Aboriginal health sector. The creation of the original definition - that health means 'life' - had an explicit aim which was to place the context of health improvement firmly in Aboriginal hands as part of a government's attempt to implement notions of community involvement in health. Gaitjil Djerkurra's assertion that Aborigines did not have a word for health and that the nearest concept was that of living itself, came at a time when there was an air of change and optimism within the Territory health sector, among staff who were inspired by the Alma-Ata Declaration and the principles of community involvement. This meant that a government was able to take (what was at the time) the radical step of utilising an Aboriginal idea for its policy framework. Elaborated versions of the original definition were taken up by health activists working for the community-controlled Aboriginal health sector. They were developed further in the 1980s, a time when both 'cultural difference' and Aboriginality were being explored by Aboriginal people. The Aboriginal definition of health was used

strategically as a means of reinforcing the need for community control when government recognition and resourcing was particularly at risk. After uncertain beginnings, the community-controlled services offering 'culturally appropriate' health care are now firmly ensconced in Australia; new services are being funded, and indigenous health is now an integral responsibility of the Federal health department.

### 3. Contesting difference in approaches to alcohol

I have alluded to the gradual development among Aboriginal people of a discourse which links cultural revival and cultural re-enactment with many aspects of healing - including recovery from addiction. In North America this has become known as 'culture as treatment'. The fact that the influences from North America were primarily coming from indigenous people with their own cultural revival already underway, confirmed and strengthened this discourse in Australia. Among many Aboriginal alcohol activists, spirituality is seen as being part of this process of recovery, partly because of a strong Christian background among some, and personal experiences of AA (with its evangelical Christian roots) among others. These Christian influences are not incongruent with the ways in which Aboriginal 'spirituality' is depicted. Many Aboriginal alcohol program managers draw associations between the spiritual orientation of AA and the spirituality of Aboriginal people (Miller 1990). Les Baird, an Aboriginal pastor based at Yarrabah in Queensland observed that Aborigines, Native Americans and other indigenous people are linked because they share a belief in total abstinence<sup>31</sup>; he associates this with spirituality:

*With the spiritual, it's the mind and the emotions that are involved. When you're drinking and taking drugs it's your emotions and your thinking that are affected as well as the physical effects, so you can't connect properly to the spiritual.*

---

<sup>31</sup> Asked what Aborigines share with other indigenous groups in their approach to drug and alcohol problems, Baird nominated abstinence, apart from the Maori who 'have adopted social drinking to some extent'. Baird has hosted visits from American consultants representing organisations such as AA, NA, ACOA, and has also visited the Nechi Institute and Poundmakers Lodge in Canada. An ex-drinker, Baird trained as an alcohol counsellor with Cliff Fua at Biala in Brisbane, and later with the Holyoake Institute in Perth and its associated organisation the Gordon Symons Centre in Darwin. Holyoake and Gordon Symons both utilise the disease-based family systems and 'Co-dependency' models.

*That's why the Canadian Indians believe in total abstinence, because they can then connect into the spirit world. (Butt-Beckett 1995, p.23)<sup>32</sup>*

### **3.1. The impact of the North Americans: cultural and spiritual approaches**

The adoption of North American slogans and practices by Aborigines in the alcohol field was notable throughout the 1990s. In Canada and the United States, the medicine wheel<sup>33</sup> and the symbol of the quartered circle is ubiquitous in treatment programs for native people. The slogan 'Keep the Circle Strong' was adopted by the Nechi Institute, for example, and this was taken up by Aboriginal people in Western Australia. An Aboriginal festival in Perth in 1993 displayed a sign at the entrance which read 'Don't allow alcohol to break the circle'.<sup>34</sup> In Alice Springs CAAAPU adopted from Canada the use of a 'naming ceremony' in some of its group sessions, in which a feather was passed around the group<sup>35</sup>. The organisation also adopted a variant of the North American sweetgrass ceremony for participants in its programs. In North American practice - for example at the beginning of a modern pipe ritual - smoke from a burning plait of sweetgrass is passed over each person participating in the ritual (Paper 1988). Such rituals are seen as an aid in cultural regeneration. At the Nechi Institute in Canada, the ritual is described as follows:

*Being Native-oriented, the morning of every training set is started with a Sweetgrass ceremony, prayers and a hand-shake circle. (Participants are not*

---

<sup>32</sup> This argument fails to acknowledge the important role that drugs play in the spiritual practices of numerous indigenous groups world-wide. The ritual use of tobacco, for example, forms a unique aspect of aboriginal religion in the Americas (Paper 1988; Wilbert 1987); peyote became a central part of the ritual of the Native American Church (Vogel 1990).

<sup>33</sup> The medicine wheel is a symbolic image of the human being, a circle divided into the four 'directions': mental, emotional, spiritual and physical. It is also called the 'Sacred Circle of Life'. A Native American healer described using it 'to examine my health and physical self. Next I examine my psychological self. Then I consider the social/cultural part of me ... Each must be healthy and balanced both in itself and with the others. Then the last, but certainly not the least, is my spiritual self' (Wood-Trost 1993, p.35). Kunitz and Levy report a Navajo alcohol treatment manager describing it as a traditional Navajo view, but they suggest that it constitutes an example of the diffusion into Navajo culture of formulations of personality organisation that were not there previously (Kunitz and Levy 1997, p.119).

<sup>34</sup> Quoted in the Western Australian journal *Yarranma* 1993 6(1):4.

<sup>35</sup> In North America, the eagle feather is believed to be imbued with spiritual meaning.

*obliged to attend prayers or ceremonies). Nechi Institute believes this allows the participants to ‘get grounded’ before beginning their learnings for the day*<sup>36</sup>

In this sweetgrass ceremony, people stand in a circle and ‘wash’ themselves with smoke from a small container which is held in front of each participant, using a particular hand-motion; each person exchanges a handshake and hug.<sup>37</sup> In Alice Springs, the leaders of CAAAPU installed an incinerator (half a 44 gallon drum, painted in Aboriginal designs) in which leafy branches were burned creating smoke. Participants stood around the drum each morning, approaching it in turn and washing smoke over themselves in an identical movement to that used in Canada. They also held hands and recited the serenity prayer (from AA) and an individual prayer and then greeted each other in turn by clasping hands and a hug.<sup>38</sup> Later the organisation formally incorporated a ‘smoking pit’ into the design of a central open-air gathering place. A ceremonial smoking of the area was held at the opening of CAAAPU, and another was organised by them for the opening of a new drug and alcohol office run by the Northern Territory government in October 1992.<sup>39</sup> Spokespersons from CAAAPU denied that the ceremony had been imported, saying that Central Australian Aborigines also used smoke in their ceremonies (Rowse 1996).<sup>40</sup> Since the early 1990s, Aboriginal people in widely dispersed regions of Australia have been conducting ‘smoking ceremonies’; indeed there has been a proliferation of such ceremonies.<sup>41</sup> Smoke was used traditionally in several ritual contexts in Australia, the

<sup>36</sup> Pamphlet published by Nechi Institute on Alcohol and Drugs.

<sup>37</sup> Fieldnotes from attendance at Nechi Institute, September 1992.

<sup>38</sup> Fieldnotes from CAAAPU, September 1993. The ‘hugging circle’ is also used in North American Indian programs (Wood-Trost 1993) but this close physical contact is often uncomfortable for traditionally-oriented Aboriginal people in Australia.

<sup>39</sup> *Centralian Advocate* 22 October 1992, p.7

<sup>40</sup> However, the Canadians also conducted North American pipe-smoking ceremonies at CAAAPU, which have not become integrated any further into the program. These have no precedent in Central Australian uses of tobacco.

<sup>41</sup> Contemporary examples of smoking ceremonies include the occasion of the handover of skeletal material at Lake Mungo in 1992; the opening of an exhibition of paintings depicting an Arnhem Land dreaming story at the National Gallery of Australia (the Wagilag Sisters) in 1997 (in which the entire audience passed through the smoke of two large fires); the cleansing of a building site prior to the construction of the new National Museum and Institute of Aboriginal Studies in Canberra in 1998; and at the handover of title to the Mootawingie heritage site in New South Wales to Aboriginal owners in 1998. On this occasion, a didgeridoo was played and local Aborigines decided that it needed to be ‘smoked’ before it could be played as it was not an instrument used locally. In August 1999 an Aboriginal man, Aden Ridgeway, was elected as a Democrat senator, and a smoking ceremony was conducted at Parliament House (by local ‘traditional owners’ of the Canberra region) on the day of his taking up his seat.

most common being the ‘smoking’ of a house or area after someone’s death. Smoke was also used to ease the pain of childbirth. Women at Yalata, South Australia told me that smoke was used as a socialisation ritual with children, in which smoke was wafted into the mouth of a young child while adults instructed him or her to ‘be good’, ‘not tell lies’ etc. Despite these and other traditional uses, there is no doubt that the contemporary proliferation of smoking ceremonies is a reinvention of a tradition, in which the principles of an existing practice are maintained, elaborated - and in this case, universalised - for new contexts. It serves to demonstrate the persistence of ‘culture’ among urbanised groups, and is a compact means of signifying Aboriginality among others. It is possible - but hard to verify - that the North American ‘sweetgrass’ ceremony, its reinvention at CAAAPU, and its demonstration elsewhere in Australia by Canadian Indians has had an influence on these wider manifestations of uses of smoke.

The cultural model, reinforced by the influence of the Canadians, is based on an emphasis on difference. It emphasises the need for programs to be run by indigenous people on the grounds that cultural differences are so great that ‘mainstream’ providers are unable to provide services which are relevant or appropriate for indigenous people. In the case of alcohol programs, sober Aboriginal alcoholics are said to be the people who ‘know best’ about how to treat other Aboriginal people who are still drinking.<sup>42</sup> Being Aboriginal, and being an ex-drinker, are qualifications in and of themselves. Running parallel with these persuasive arguments there is a stress on the links shared by indigenous North Americans and Australians: their shared histories of dispossession, colonisation, and cultural destruction. The emphasis on these shared associations serves to polarise indigenous from non-indigenous models even further.

---

<sup>42</sup> This is an indigenous version of the position of Alcoholics Anonymous which maintains that ex-drinkers know more about alcoholism than do professional clinicians. The employment of minimally-trained (or untrained) paraprofessionals in these and other services serves a number of additional purposes: it fills a gap in types of work which are unpopular among professionals (such as drug and alcohol services), and these positions provide alternative channels of upward social mobility for people with low or no educational qualifications. In the drug and alcohol field, the employment of ex-users also serves to maintain their sobriety by providing them with roles conditional upon that sobriety (Fua 1987; Kahn and Fua 1992).

### **3.2. The impact of the North Americans: treatment centres and abstinence**

By the time the North Americans visited Australia, the disease model of alcoholism was already well-entrenched as a dominant orientation among large sections of the Aboriginal alcohol workforce, as we have seen from the discussion of the House of Representatives Standing Committee enquiry into Aboriginal alcohol problems. The indigenous consultants from Canada, and other non-indigenous American visitors to Aboriginal programs, strongly reinforced this already popular view. Indeed, the disease model was extended to cover the practice of petrol sniffing as well.<sup>43</sup> One Canadian spokesman, (inaccurately) citing the Australian Medical Association and the WHO to support his assertions on disease-definitions, was quoted as follows:

*Alcohol is a disease and should be treated as such. It is recognised as a disease by the World Health Organisation and the Australian Medical Association, among others. The old method of treatment, of punishment, control and media campaigns, did not work. Would cancer respond to punishment or advertisements? No. Seeing people trying the same method of treatment over and over again is my definition of insanity. Our society is structured to keep alcoholics in denial. How many times have you heard "if you really wanted to, you could give up"? Alcoholism is a disease. Can you give up cancer?<sup>44</sup>*

Staff of the CAAAPU organisation in Alice Springs (originally established and strongly influenced by the Canadians) re-stated the arguments for biological vulnerability which had first been expressed in the mid 1970s, to which I have drawn attention in the analysis of submissions to the House of Representatives enquiry. For example, a team evaluating the program was told of an

---

<sup>43</sup> Eric Shirt attended a bush meeting at Umuwa on the Pitjantjatjara Lands in December 1993, called to discuss petrol sniffing strategies. Shirt urged Pitjantjatjara people to send their petrol sniffers to CAAAPU for 'treatment' and subsequent 'cure', saying that petrol sniffing was a chemical dependency sickness, just like alcoholism (Fieldnotes 14/12/93).

<sup>44</sup> Katherine Times 11 April 1994, p.3

*...Aboriginal form of alcoholism - a particularly virulent and disabling form. The ways in which alcoholism is a disease for white people are not necessarily relevant to the Aboriginal case ... Because Aboriginal alcoholism was so severe, abstinence is the only goal for Aboriginal people now and in the foreseeable future. Moderation might be a reasonable goal later on, but not now* (Rowse 1996; Rowse and Miller 1994, p.30).<sup>45</sup>

Echoing the language used by the Canadians, workers in the organisation also espoused the view that those who argue that alcoholism is *not* a disease must be 'in denial'.<sup>46</sup> They were critical of perspectives (such as those of social scientists, especially anthropologists) which emphasise the social context of alcohol misuse, rather than focus on the disease itself. In a marked reversal of earlier attempts by Aboriginal people to fuse the disease concept with theories of social deprivation, they eschewed the arguments that unemployment and inadequate housing contribute to alcohol problems. These were said to provide 'rationalisations' for alcoholics (Rowse 1993, p.397; Rowse and Miller 1994, p.29). In so doing, they dismissed all attempts to provide a socio-political explanation for Aboriginal alcohol abuse.<sup>47</sup> This position meant that CAAAPU (at the time a key centre for commentary on alcohol issues) declined to add its support to various anti-alcohol actions taken by Aboriginal people in Alice Springs, which were directed largely at licensed outlets, the suppliers of alcohol. These decisions were taken on the grounds that

<sup>45</sup> There is a further association with earlier preoccupations. Reminiscent of Dr Kalokerinos' belief that large doses of Vitamin C were a solution to Aboriginal alcoholism, one Canadian Indian consultant was convinced that Aboriginal alcoholism was associated with a dietary deficiency, and sold his own imported supplies of vitamins to Aboriginal clients of a treatment program. He also attempted to persuade a medical officer at a treatment centre to take blood and hair samples from the Aboriginal clients, in order to test them for chemical and mineral deficiencies (Fieldnotes).

<sup>46</sup> Peele provides a spirited attack on the tendency for proponents of the disease model to treat any disagreement with their position as 'denial' (Peele 1989, p.79). It is, he says, a catch-22. Haaken, studying women and the therapeutic limits of constructs associated with the recovery movement (AA, ACOA) in the US, draws attention to its hypersensitivity to criticism, also reporting that any reservations about the treatment processes were dismissed as 'denial' (Haaken 1994, p.256).

<sup>47</sup> Haaken found that in their treatment of women, groups such as Adult Children of Alcoholics (ACOA) depoliticised the difficulties that pervade women's lives (Haaken 1994, p.244). This lack of refinement in interpretations of the causes of alcohol abuse is in marked contrast to those evident in some other indigenous and minority groups. For example in Puerto Rico, mediums identified two major causes of alcoholism: material causes such as social difficulties and poverty, and spiritual causes such as the presence of an evil spirit. Although both are 'folk' definitions they recognise that there is a difference between problem drinking and full-blown alcoholism (Singer and Borrero 1984, p.255).

the drinker is responsible for ‘bending the elbow’; that this is the individual’s - not the licensees’ - responsibility.

As shown in the testimony to the House of Representatives Standing Committee enquiry into Aboriginal alcohol problems, there is a history of an Aboriginal ‘hard-line’ position on alcohol consumption. At the time when mainstream policies of harm minimisation gathered pace in the 1980s, so too did Aboriginal criticism of these; the uncompromisingly anti-moderation, anti-harm reduction views held by the North American advisors who came to Australia provided backing to these Aboriginal criticisms. Some incidents which occurred in Alice Springs provide examples of this. The Commonwealth government since 1987 has attempted to provide information on ‘standard drinks’ to members of the public, as well as promoting the idea of responsible drinking with national guidelines produced by the NHMRC. Low alcohol beverages (particularly beer) are promoted in this context. In Alice Springs, CAAAPU leaders were critical of these approaches, seeing them to be complicit in a culture of drinking. Distinctions between harmful and non-harmful drinking,<sup>48</sup> and education about different strengths of alcohol were not supported, as they were perceived to be further opportunities for alcoholics to deny their dependent status (Rowse 1993, p.397). The Northern Territory government took a leading role in Australia in attempts to deal with the excess consumption of its citizens at this time, and supported several detailed enquiries.<sup>49</sup> It also started the Living with Alcohol program, funded by a hypothecated tax on alcohol which raised approximately \$10 million annually. Funds raised by the tax are used for prevention, rehabilitation and treatment programs. In 1992 the Northern Territory government paid for television advertisements as part of a wider media

<sup>48</sup> The National Health and Medical Research Council has produced drinking guidelines based on ‘standard’ drinks (one standard drink being a beverage containing about 10 grams of absolute alcohol), recommending that men should drink no more than 4 a day, and women no more than 2. The NHMRC (1992) categorises alcohol consumption into three: responsible, hazardous and harmful. Responsible drinking is one carrying an acceptable level of risk; ‘hazardous’ consumption likely to lead to harmful consequences for the drinker; and ‘harmful’ consumption is that known to have caused tissue damage and/or mental illness.

<sup>49</sup> For example the Legislative Assembly convened a sessional committee to report on *Measures for Reducing Alcohol Use and Abuse in the Northern Territory*, which made some wide-ranging recommendations, including a levy on alcohol, a reduction in the number of liquor outlets and controls on sales of alcohol through supermarkets and other off-licences (Legislative Assembly of the Northern Territory 1991).

campaign called 'Lighten Up', urging everyone in the population to drink low-alcohol beer.<sup>50</sup> These were to be shown on Imparja TV, an Aboriginal-owned commercial channel with a footprint covering one-third of Australia's central land mass, with about 90,000 viewers, 40 per cent of which are Aboriginal. The Imparja Board argued that showing the ads breached their policy which stated 'The Board will not accept revenue by selling its services for the promotion or publicising the availability of alcoholic products' (Maher and Tilton 1994, p.32). The advertisements clearly showed *brands* of light beer. Despite the fact that the advertisements were promoting safer drinking, Imparja interpreted the ads as promoting drinking itself. Workshops with Aboriginal viewers produced comments which revealed confusion about the 'lighten up' message.<sup>51</sup> While the Imparja Board had no formal linkages with CAAAPU or with the Canadians, the decision was indicative of a generalised 'hard-line' approach on alcohol.<sup>52</sup>

Other mainstays of Australian government policy were dismissed by the Canadian advisors, and subsequently by Aboriginal people influenced by them. Prevention was one of these. At a health professionals conference in Alice Springs for example, one visiting consultant spoke on prevention :

*Once you have [the disease] causes don't matter. You have to address the primary illness which is alcoholism. You can do as much as you want about the causes and you're not going to fight alcoholism at all. You can talk prevention also but it ain't going to impact alcoholism at all. Prevention seems to be always a nice word, a you know, a catch type of thing. But it is really a big cop out. It really is a big cop out (Shirt 1993).*

<sup>50</sup> Low alcohol beer is a form of de-alcoholised beer from which the surplus alcohol is evaporated. Swan Special Light for example, (0.9% alcohol) was introduced in Western Australia in 1983, and the Australian Associated Brewers reported soon after that light beer was showing good sales growth within a generally declining beer market.

<sup>51</sup> One comment was that the government was contradicting itself: 'One minute they tell you not to drink, then they put on these ads'. Another person asked 'What were they trying to say? Are they saying drink more or cut down?' (Maher and Tilton 1994, p.34).

<sup>52</sup> Another example of this came from a 'Healing our People Everywhere' conference in Cairns in 1994 organised by the Bama Healing Centre run by local Aboriginal Les Baird. The conference agreed on a recommendation that 'The introduction of controlled drinking was a backwards step in the war in the control of substance abuse'.

Similarly, harm reduction policies were criticised by an Aboriginal woman who had returned from visiting the Nechi Institute in Alberta:

*Harm reduction policy is: ‘cr-p, that’s absolute garbage. I really don’t believe the government is serious in this country. The thing that struck me … in Canada, was how serious this government was! How much money they gave. All these treatment centres! (Wroe 1995, p.10)*

Indeed the provision of treatment centres became the focus for many Aboriginal groups who had had contact with the North American consultants, and this emphasis on tertiary treatment partially explains the antipathy to prevention and harm reduction. Some spokespersons expressed the need for treatment centres in an uncompromising way, in which any opposition or questioning was interpreted as denial of the extent of the problem - or even as a form of sabotage. Speaking in April 1991 in Alice Springs, Eric Shirt expressed this thinking as follows:

*I would encourage everybody to support these people [those setting up treatment centres], because treatment centres are about saving human life … But if you bad mouth that centre … We have a saying among us alcohol workers. Those who don’t help, but who just sit back and criticise we treat this as high treason. You don’t criticise people who are saving our people’s lives’ (Hazlehurst 1994, p.114).*

### **3.3. Debating models of addiction: abstinence goals**

The discussion so far has drawn attention to the tenacity with which the managers and staff of Aboriginal alcohol programs have adhered to the disease model of alcoholism (usually in conjunction with the use of the 12 step approach) and have rejected the goals of moderate drinking and harm reduction, in favour of abstinence goals. While I do not

intend to engage in a lengthy analysis of the arguments around the efficacy of this approach,<sup>53</sup> it is important to highlight these briefly in the Aboriginal context.

There are several ways of interpreting Aboriginal adherence to the disease model of alcoholism and its associated goal of abstinence. In a sense, personal abstinence is a solution for Aboriginal people to the lingering ideological problem of prohibition. This is because, in effect, it constitutes 'self prohibition' based on individual choice, rather than as the result of the imposition of an external control over access, which is politically abhorrent to some people as a result their sensitivity about prohibition in years gone by. It thus recognises and enacts the sense of personal autonomy discussed above. Because of the discriminatory and paternalistic overtones associated with prohibition, it was more difficult for Aboriginal groups or organisations to espouse control measures which smacked of it. Promoting abstinence offers one way out of this problem.

Abstinence is appealing to Aboriginal people for other reasons. The pressure to consume to excess is continuous, brutal (psychologically and physically) and all pervasive in many Aboriginal contexts (Brady and Palmer 1984; O'Connor 1984; Sansom 1980). There seems to be overwhelming evidence that it is easier for Aboriginal drinkers *in particular social and environmental circumstances* to give up alcohol altogether, rather than to attempt to moderate their intake. These are, I suggest, circumstances where people are living in rural or remote communities with long-standing and entrenched norms of heavy drinking, involving sharing and exchange of both alcohol itself and other resources. In interviews with indigenous people who had made changes to their drinking, only two individuals (out of 43) interviewed continued to drink, in moderation. All the other individuals had chosen to abstain. These abstainers were virtually all subjected to intensive derision and mockery when they announced their new status and attempted to maintain that status. In order to withstand this pressure and survive socially, new

---

<sup>53</sup> See Sanchez-Craig and Lei (1986) for discussion on the disadvantages of imposing the goal of abstinence on problem drinkers. They argue that controlled drinking programs should be offered even to problem drinkers (Miller et al. 1992). Peele (1993) observes that American clinicians refuse to tell excessive drinkers to drink less, and that the US has systematically eliminated efforts to help people reduce consumption in favour of instructing all problem drinkers to abstain, notwithstanding the fact that the abstinence prescription fails in a sizable majority of such drinkers.

abstainers engaged in elaborate strategies of avoidance, counter-argument and legitimation which they were forced to uphold for about two years or more after giving up alcohol. For most, it was only after a substantial period that their former drinking partners finally accepted their new status. It is clear that it would be virtually impossible for these individuals to attempt to drink in moderation during this time. The following extracts from interviews<sup>54</sup> illustrate these points.

*They force me for drink, my brother-in-laws, my brothers, my nephews, my uncles. I say 'no, no I don't like to drink, you can have them'. They keep on, but I can't ... No matter my brother-in-law's kids they come here drinking in front of me, but I never feel like it. (K.S.)*

*I just told them 'mate, I don't drink any more, I hate the stuff'. They was really distraught and they said 'oh, you gone stupid'...They tried, they tried [to persuade me] for seven years. But I stood my ground. I said 'no, I've never felt like this in my whole life and as far back as I can remember'...And I said 'no way mate, I'm not gonna give it up now'. It's making a stand...P.I.)*

*And friend would come along, 'oh, she's come back [from hospital], we'll buy you dozen'. So my grandfather bought a six can for me. He put it in a plastic bag. And I said, 'no, I'm not taking that' ... 'Oh, you liar. C'mon, c'mon'...People coming back with grog and I keep saying 'no, no, no'. They listen after two years. Two years later. Two years, they stop asking me then. And I used to tell them, you know. Then, this is 1982, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92. Eleven years. Straight. Not even one little taste. I left cigarette, gave up smoke and grog as well. (G.D.)*

*They know now. But sometime when I go into town someone call out to me from inside the pub 'hey have one of these'. They just make a joke on it. No way. I*

---

<sup>54</sup> Interviews conducted between 1992 and 1994 in Belyuen, Katherine, Binjari, Timber Creek, Amanbidji (Northern Territory), Yalata and Ceduna (South Australia) and Canberra.

*might go into pub and have a game of pool, but I'm not touching that stuff. They try hard to get me back on the drink again now. Trying to, 'come on'. 'Oh, that's no good, that stuff kill you. Make you no good'. Turn your face a different way. (O.J.)*

*It was hard. Yeah, at the pub here at Timber Creek, Kununurra, with my relations in Katherine, they say 'come on, I grew you up' and all the other things you know. I told them, 'that's your way of living not my way of living. I came over that hill, I don't want to go back in'. When they say 'you don't love me any more', I say 'Well, that's it. Well if you finish that together then I'll love you...I can be your friend because I'm sober. When I get drunk with you we get into hatred, we fight together. (R.H.)*

Several issues stand out in these personal accounts, particularly the role of close relatives who persistently attempted to break the will of the ex-drinker, and the emotional blackmail they brought to bear on him or her. Another significant element to emerge is the sense in which people felt they were 'making a stand', that their abstention became a matter of principle. Several interviewees talked about not 'backing down' and said that they would be 'shamed' if they went back to drinking *in any form*. One of the two previously heavy, and now moderate, drinkers I interviewed (a senior health worker) said that his decision to change was associated with his awareness of the medical problems associated with heavy drinking, and the prevalence of diabetes among his family members:

*...it was for that reason, I used that to help me to slow down on my drinking. This change has come about in the last two years, its only just in the last twelve months that I've actually started drinking the light can. On and off I've introduced it to others and some actually drink it...It's the only thing's available, they didn't have any money to buy any of the more stronger beverages, but they're more used to wines, like moselle, strong beers. (H.S.)*

Despite his switch to low-alcohol beer, this health worker was nevertheless considering total abstention. When asked why he did not intend to continue to drink in moderation, he implied that he would feel hypocritical if he was still drinking at all, while giving others advice:

*Mainly its connection with my work. Because I'll be later telling people to go on that line, go that way, looking at the community the way it is, once Belyuen was such a pretty little community, like to get it back to that again.*

In short, there are sound reasons for the choice of abstinence over that of moderation for Aboriginal drinkers. While some chose abstinence because of the serious nature of their medical condition, for many the choice of abstinence was said to be because of thoroughly social and interpersonal reasons.

### **3.4. Are these features specific to indigenous people?**

I have described aspects of Aboriginal social processes which help to explain the persistence of abstinence as a goal for those changing their drinking behaviour. These features are derived from long-standing perceptions of personal autonomy and the ways in which Aboriginal people have tolerated each others' actions. They also derive from the constraints imposed by kinship and close associations among people who live, for the most part, in closely interlocking networks of known others. However, as with other supposedly 'Aboriginal' traits, there are parallels elsewhere. I described the tolerance shown towards drinkers - which extends on occasions to collusion in their abuse of alcohol - as a coping mechanism shaped by Aboriginal understandings of interpersonal etiquette, but it is important to point out that these behaviours are not restricted to Aboriginal people. Families in countries as disparate as Mexico and England engage in similar colluding behaviours in response to excessive drinking (Orford 1992). I also described the normalisation of heavy drinking, the role of alcohol in affirming social relations, and the derision heaped on individuals attempting to extricate themselves from this. These behaviours bear a remarkable similarity to the situation in England up until

the 1830s where shared daily drinking was a symbolic affirmation of social and community relationships prior to industrialisation. ‘*Not to drink was tantamount to a complete withdrawal from socially meaningful existence*’ and people were ostracized and denied assistance for refusing to participate in reciprocal drinking rituals (Adler 1991, p.381). This is a historical example, but drinking and its associated conviviality is an integral part of Australian life today, and its functions in maintaining human social interactions are particularly notable in small country towns. In a study of such a town, I found that alcohol was part of virtually all social events, including church and school functions: if it was not available, people (‘especially the fathers’) simply would not attend. ‘If you don’t drink, you don’t get on socially’, I was told (Brady 1988, p.25).

Abstinence rather than moderation is a key feature, not only of Aboriginal ways of dealing with alcohol abuse, but is also common among non-Aboriginal people who were previously abusive or dependent drinkers. This is because addictive behaviours are ‘overlearned’ behaviours: one extreme (dysfunctional abandoned consumption) naturally swings to the other (total abstinence). If individuals have learned that there are only two patterns of behaviour, abstinence or heavy use, then it is not surprising that if they return to the behaviour (drinking) then the old pattern re-emerges. Without alternative patterns of use it is only to be expected that many individuals will vacillate between the two learned alternatives (Allsop 1990, p.148). These insights are derived from the mainstream literature on addiction. They show that abstinence is an expectable goal for Aboriginal people - not because they lack ‘traditional’ mechanisms for controlling intake, or because there was no alcohol use pre-historically - but because the learned pattern, and the pattern of intake to which people are constantly exposed, is one of extremes.

It is also important to point out that abstinence seems easier to *sustain* for non-Aboriginal heavy drinkers as well as Aborigines. A long-term follow-up of alcoholics (Miller et al. 1992) who had received behavioural self-control training, concluded that some of these alcohol dependent individuals could achieve non-problem drinking, but that it was ‘questionable whether controlled drinking should be tried at all with persons showing *severe dependence and a family history of alcoholism*’ (emphasis added). The authors

recommend that if drinkers cannot progress towards moderation within twelve months, they should be strongly urged to change to an abstinence goal (Miller et al. 1992, p.259).

### 3.5. Debating models of addiction: the disease metaphor

The disease model of alcoholism is often said to be holistic, in that it acknowledges biological predisposition, pharmacological reinforcement of behaviour, accumulating organic damage, entrenched cognitive patterns, family and developmental influences. It was undoubtedly historically useful as a concept with which to combat puritanical views of moral decay, and it helped alcoholics to have access to more humane treatment and other entitlements, rather than subjecting them to prejudice and stigma (Jurd 1996; Khoury 1989).<sup>55</sup> Heuristically the notion of excessive drinking being a disease may also function as an explanatory device for individuals struggling to understand how it could have been possible for their lives to become so unmanageable - acting as a device which relieves the individual of blame for their condition and/or behaviour. Some of these aspects of the disease model may be appealing and relevant to Aboriginal people, particularly the deflection of blame away from the individual on the grounds that he or she is suffering from a disease.

It is important to reiterate nevertheless, that both the disease model of alcoholism and the traditional treatment goal of abstinence have been under challenge since 1973 (Lewis 1992a, p.147) when the medical director of the alcohol education centre at the Maudsley Hospital in London argued that such a model was too narrow, restricted understanding of aetiology, delayed diagnosis until the stage of overt symptoms, and encouraged management in terms of drug therapy. Milner, advising the Australian government, criticised it at about the same time. Prominent North American critics (although fewer than elsewhere) include Jeffrey Schaler (1996), who takes the view that the ‘disease’ of alcoholism was *invented*, not discovered, by Benjamin Rush in 1785; and Stanton Peele (1989) who sees the expansion of the definitions of ‘disease’ to addiction as a gerrymander. What concerns us here, however, are its specific implications for

---

<sup>55</sup> Khoury questions whether this has been the case for Aboriginal alcoholics (Khoury 1989, p.234-5).

*indigenous* people. Commentators (both native and non-native) in the United States have raised for discussion some of the apparent disadvantages in utilising the disease model which have a particular bearing on indigenous communities.

May, Miller and Wallerstein (May, Miller, and Wallerstein 1993) are some of these researchers. They proposed an elaboration of the motivational interviewing technique, suggesting that it could be used as a public health intervention with whole communities of people, not just with the individual<sup>56</sup>. They suggest that community mobilisation is a concept not too distant from the idea of motivation as it is used in individual therapy. They note that such approaches received a fillip when the Ottawa Charter (1986) nominated the *strengthening of community action* as one of its five principles. ‘These include community capacity-building efforts to replace ideas of disease with those of individual self-efficacy and community empowerment’ (May, Miller, and Wallerstein 1993, p.69). Community action can be instigated and motivated through spark topics (such as crises), and by community development work utilising some of the principles of motivational interviewing (expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance and supporting self-efficacy). In this process, community members can be assisted to make the link between their individual troubles and the community-wide extent of a problem (eg alcohol-related violence, intoxication, deaths from car accidents). However, and this is a crucial point, May, Miller and Wallerstein (May, Miller, and Wallerstein 1993, p.76) found that,

*Many times, the disease analogy used in individual therapy regarding substance abuse has left a community feeling powerless over a problem...communities have the potential to have an impact on many factors related to substance abuse, but the terminology of illness gets in the way by turning attention to individual interventions and by promoting the notion that only a small percentage of ‘sick’ people in the community are creating the problems.*

---

<sup>56</sup> Motivational interviewing is a non-directive brief treatment technique based on Prochaska and diClemente’s ‘stages of change’ model - one of the most important therapeutic innovations of the 1980s (May, Miller, and Wallerstein 1993, p.90).

Another team of highly respected US researchers has expressed concern that the disease model reinforces powerlessness among native communities. In 1985 Beauvais and LaBoueff cautioned:

*When the lack of personal responsibility is combined with a belief in the inevitability of alcoholism, there develops a sense of fatalism that may defy treatment efforts. This sense of futility is felt by communities as well as individuals - thus there is an acceptance that alcoholism is inevitable, and possibly untreatable. (Beauvais and LaBoueff 1985, p.158)*

The relevance of these concerns to Australian attempts to mobilise community-based interventions should not be underestimated. I have drawn attention to the fact that Aboriginal treatment program managers declined to support several large-scale public health and community participatory actions around alcohol which took place in and near Alice Springs. Aboriginal people in many parts of the country already subscribe to understandings of intoxication and of alcoholism itself, which emphasise that the individual is not responsible for his or her actions while under the influence of alcohol. Drunken people are 'not themselves' and their excesses are allowed and excused (Brady and Palmer 1984). Blame (for accidents, illness or misbehaviour) is frequently externalised. I have also indicated that many Aboriginal people seem to prefer to believe that they have inherited vulnerabilities to alcohol rather than take the view that excessive drinking could be a learned behaviour. All these socially-derived meanings and beliefs, *which already exist*, predispose communities to acceptance, tolerance and non-interference - in other words, these understandings militate against community mobilisations directed at the supply, demand, and uses of alcohol. When these pre-existing orientations are coupled with the message of the disease model - that people have a sickness which will never be cured - together with the pervasive sense of political powerlessness among Aboriginal people, there is a strong likelihood that community impotence, rather than motivation, will be the outcome.

Although he does not specifically address indigenous contexts, Schaler raises similar points saying that the more people believe in their inability to moderate their use of drugs, the more likely they will not be able to moderate it - a self-fulfilling prophecy.

*There is no force alien to oneself that is responsible for one's behaviour. Believing a disease makes people drink is illogical; it ignores empirical findings on self-efficacy. It goes against commonsense. It also individualises and de-politicises the culture context within which drug consumption occurs (Schaler 1996, p.189).*

It has been pointed out that disease-model abstinence-based approaches typify relapse as being a major problem, and that the dominance of this model has meant that little interest was taken in relapse issues until recently (Allsop 1990; Donovan 1988). Relapse is also a problem for workers in a program if program managers treat it as 'failure' on the part of the counsellors as well as the clients. This can exacerbate a sense of failure, lack of self-efficacy and inadequacy among counsellors working in rehabilitation centres. Aboriginal dependent drinkers, like all dependent drinkers, often relapse after courses of treatment or rehabilitation. Viewed from a different perspective, relapse is *part of the process* of recovery (Prochaska and Di Clemente 1986). Writing specifically on indigenous drinking and healing interventions, Joan Wiebel-Orlando has suggested that judging success by the criteria of life-long abstinence 'hardly represents modal real life heavy drinking career trajectories'. She proposes that this is not always a culturally appropriate goal, and significantly, that

*The abuse/intervention/recovery/use and abuse cycles which longitudinal research allows us to observe may be an indigenously developed self-regulatory pattern upon which institutional interventions can be modeled so as to afford them more cultural relevancy and, in that context, more potential success in stemming the negative sequellae of non-normative drinking behavior. Perhaps one substance abuse intervention goal can be the lengthening of the periods of abstinence, quiescence, and moderation and to foster self-regulatory drinking*

*behavior so that culturally appropriate drinking bouts fall short of life-threatening events either to the drinker or his associates (Wiebel-Orlando 1989, p.152).*

This is a far more thoughtful approach to relapse, which takes cognisance of the realities of everyday life, and the cultural relevance of drinking for American Indian (and indeed Aboriginal) substance abusers. In view of the supposed adherence to cultural norms and the congruence with Aboriginal lifeways of the disease/abstinence-oriented programs, it is remarkable that the factors to which Wiebel-Orlando refers have not been adequately dealt with.

Two native American researchers have provided a postcolonial critique of psychology, in which they also draw attention to the fact that the disease model places alcohol problems in an a-historical, decontextualised and medicalised paradigm. They see it as a further manifestation of a hegemonic (Western social science) discourse, and accuse the 12 step model and its 'denial-labeling paradigm' of placing native Americans in a double-bind by discounting much of what is culturally valid for them (Duran and Duran 1995, p.102).<sup>57</sup> They assert that native Americans frequently resent the fact that AA is 'forced' on them in native treatment programs, which often have overtones of zealous missionising.

### **3.6. An Aboriginal definition of alcoholism**

Notwithstanding the range of perspectives (among alcohol theorists and among indigenous program managers) on the disease model and its perceived advantages or disadvantages as a means of dealing with Aboriginal alcohol abuse, Aboriginal people maintain that they have their own theories on alcoholism. What has emerged is *an Aboriginal definition of alcoholism* which, like the Aboriginal definitions of health, seeks to combine a number of interlocking factors. An Aboriginal model of alcoholism is one which conceives of it as a disease introduced by non-Aborigines into a population which was made particularly and peculiarly vulnerable to alcohol abuse because it had no pre-

---

<sup>57</sup> See Room (1985a) who reminds us that addiction is itself a culture-bound concept.

existing knowledge of alcohol, assisted by the assaults of colonisation, dispossession and cultural loss. Like the Aboriginal definitions of health, this model blends physiological disorder with social, historical and emotional explanatory factors. It is, in this respect, 'holistic'. However, the model depends to a large extent on assertions that Aborigines were particularly vulnerable to alcohol, that it was introduced to them by outsiders, that they had no prior knowledge of its use, nor any social controls with which to order its use. Indigenous people are portrayed as living in an alcohol-free Eden prior to the British invasion. This assertion must now be questioned. There is scattered evidence from some early commentators and diarists which indicates that there was pre-existing alcohol use among some Aboriginal groups. The most detailed account is in the Tasmanian journals of G.A Robinson written between 1829 and 1834 which describe mildly intoxicating drinks being made from the sap of the 'mellifluous' cider gum (*Eucalyptus gunnii*). The trees were tapped like the maple, and Robinson was told that the juice, similar to a coarse cider, frequently made the Aborigines drunk (Plomley 1966, p.534; Roth 1899, p.94). There are also accounts of fermented liquors being made in Western Australia from the soaked cones and blossoms of a banksia (Roth 1904); in the Northern Territory (Basedow 1929), and in south-western Queensland (Duncan-Kemp 1933). The Aborigines of Lake Boga, Victoria made a stupefying drink from the root and bark of *Santalum murrayanum* (T.L. Mitchell) (Stone 1911). We know nothing about the existence of social controls over the use of these beverages, nor anything of the circumstances under which they were consumed.

It is likely that these alcohols used before contact, or in the early days of the colony, were neither strong enough nor drunk in sufficient quantities to produce the type of drunken comportment which we now associate with disorder and injury. Even if people did make fermented beverages, there was not the unfettered access to large amounts of relatively high alcohol content drinks such as cheap fortified wine which followed widespread European settlement on the continent. Changes in availability such as this have historically produced change in other settings, such as 18th century Britain (with the availability of distilled spirits), and among Thailand's hill tribes (who have switched to injecting heroin after having traditionally smoked opium). Nevertheless, these early

Australian accounts demonstrate that Aboriginal groups in different parts of the country did utilise fermented drinks, as well as chewing the psychoactive drug *pituri* (*Duboisia hopwoodii*) and numerous potent indigenous tobaccos. The continent we now call Australia was not alcohol- or drug-free.

## Conclusion

This discussion has taken the form of a critical unpacking of some of the dilemmas brought about by an emphasis on difference. I have made a critical appraisal not in order to devalue or to dismiss these, for there is a need for culturally sensitive and culturally recognisable interventions in indigenous health and substance abuse. I have done so in order to draw out the ways in which this stress on the supposedly fundamental differences between indigenous people and the majority population may have unhelpful consequences.

In Aboriginal adaptations of culture as treatment and healing there is an implicit tendency to credit and valorise the mysterious powers of exotic ideas - either because they come from far away (as in the case of alcohol treatment and North American influences), or because they emanate from 'native' Others (as in New Age dealings with Aboriginal issues). Gilbert Lewis points out that this readiness 'goes with a certain romanticism about exotic people' (Lewis 1993, p.193). Lewis also asks about the grounds on which we attribute efficacy to some treatment we see in another society. In the case of Aboriginal approaches to substance abuse problems, do we apply double standards in our judgements, one set for Aborigines, and another for everyone else?<sup>58</sup> Would a small group of North American alcohol treatment entrepreneurs have been allowed to have such an influence on the majority Australian population? Joan Wiebel-Orlando urged cross cultural researchers in the addictions field to adopt a more critical stance, on the basis that nonevaluative description of healing interventions mar our ability to be of

<sup>58</sup> For example, researchers have investigated whether there is any evidence for the healing power of religious faith, finding that even in the best studies, any association between religion, spirituality and health is weak and inconsistent (reported *Sydney Morning Herald* 20/2/99) (Vyse 1997). Researchers would probably be unwilling to subject Aboriginal healing programs which utilise spirituality to similar scrutiny.

professional help to indigenous people (Wiebel-Orlando 1989). In keeping with her suggestion, I propose that the issues raised in this chapter provoke some important questions. Have Aboriginal people (and indeed government bodies) been subjected to a form of psychological colonialism (albeit indigenous) from North America? On the other hand, do the syncretic approaches encouraged by North American First Nations people merely serve to reinforce a pre-existing recognition among Aboriginal people that their culture and identity is a medium of self-affirmation and, as a consequence, a tool in the fight against addiction? Are New Age and alternative psychotherapeutic practitioners offering indigenous people the quality and type of intervention they need - indeed are they offering any 'intervention' at all? Is there anything wrong with transposing and adapting the customs and practices of other indigenous cultures? Why is it important for Aboriginal people to revive their own cultural forms in addictions treatment when 'any culture will do'? <sup>59</sup> In view of the questions raised in this chapter, a more appropriate course to follow in shaping treatment approaches might be to engage with a process of *redefining* the culture, not simply drawing upon it in various ways (Gibson 1987).

Assertions of difference in the way in which Aboriginal people conceptualise health and alcoholism have formed one of the bases for political arguments which underlie the need for special services and for the distinctiveness and maintenance of Aboriginal cultural forms. They have provided a useful alternative position to that of the mainstream. Part of this process has involved aligning the 'alternative' Aboriginal view of health with that of the WHO, which is accepted by health activists as being in keeping with holistic indigenous definitions. In order for this to make sense, the fact that the WHO definition was itself promulgated largely by Europeans (many of whom were medical professionals), and the fact that WHO's philosophy of achieving complete health and well-being for all was based on thoroughly *Western* beliefs in progress, have both been downplayed. In the case of alcoholism, the need to assert difference led Aboriginal people to emphasise (and biologise) their vulnerability, and to present their societies as having been colonised by the introduced disease of alcoholism. In this process, people

---

<sup>59</sup> These issues were first raised in Brady (1995b) which prompted further discussion by MacLachlan (1997).

have largely chosen to follow models of disease (with associated biological features) and to put aside arguments that styles of drinking are learned and can be un-learned or re-learned. This, I argue, has been unhelpful to the extent that alternative models and potentially fruitful ‘mainstream’ approaches have been largely ignored or dismissed as being culturally inappropriate. It has meant that tertiary residential treatment has been allowed to persist as the dominant model provided to Aboriginal people with alcohol problems, to the exclusion of secondary prevention approaches. It has made open debate about the relative merits of harm reduction more difficult, as well as impeding exploration of how harm reduction and secondary prevention possibilities could be communicated to Aboriginal people.

The primordial discourse which stresses fundamental differences meant that ‘Western’ and ‘indigenous’ approaches to health were depicted as being polarised. In order to accomplish this it was necessary to elide the heterogeneous histories in the West of ‘alternative’ traditions in which nature, the spirit, the balance of psyche and body were all a part of health and healing. Instead, the dominant Western bio-medical orientation has been presented as being the *only* model. The polarisation of these two perspectives, and particularly the implication that Aboriginal people hold fundamentally different and alien understandings of health and illness, has contributed to further reification of Aboriginal people, setting them apart. What seems to have happened is that the Western tradition in its solely reductionist form has been invoked as a rhetorical device, in order to create a notion of ‘holism’ in indigenous traditions to pose in opposition.

This has occurred in other disciplines as well, notably in the philosophy of science, and in ecology. For example, writing on the philosophy of science, Agrawal (1995) (1995) questions the divide that has been created between indigenous and scientific knowledges, suggesting that this separation denies both history and the dynamic exchanges that have taken place between different cultures.<sup>60</sup> Like others such as Murray

---

<sup>60</sup> Agrawal’s position is critically examined by several contributors to a dialogue on the categories of indigenous and scientific knowledge in the *Indigenous Knowledge and Development Monitor* 1995, 3(3):3-19. One commentator points out that Agrawal equates ‘scientific’ with ‘Western’ knowledge, when in fact all scientific knowledge is clearly not Western, nor is all Western knowledge scientific.

(1993) and Turnbull (1993-4), he questions the standard appreciations of Western science as being objective and rational, as existing somehow ‘above’ culture, noting that the so-called scientific method is often patchy and heterogeneous: a motley. Agrawal notes that philosophers of science have given up hope of finding a methodology which would distinguish science from non-science. In view of this it is strange to find advocates of indigenous knowledge holding up improbable straw men in their attempts to valorise the indigenous and the local. In ecological studies, the uses and management of land and resources by indigenous people have been reified (a notable example being the work of Knudtson and Suzuki) (Knudtson and Suzuki 1992), while the West is depicted as having committed the ‘original sin of civilization’ from which only Paleolithic cave dwellers are exempt (Schama 1996). In contrast to these essentialist depictions, other writers have contributed more nuanced examinations of the suggestion that deeply-felt associations with place and landscape are the prerogative only of indigenous peoples. They have explored Western associations with place, landscape and sites of remembrance in America (Buell 1995), Europe (Schama 1996; Winter 1995) and in Australia (Read 1996).

This polarisation of the characteristics of ‘Western’ and ‘indigenous’ world views which has occurred in the discourses on science, knowledge, landscape, and ecology as well as health and substance abuse, can be understood as a strategising device utilised in the context of the struggle over the uneven distribution of resources and political power. It is important, however, not to take for granted the supposed antagonism between these ‘Western’ and ‘indigenous’ traditions. Both are assemblages of elements interacting with one another, and the reality is that indigenous people utilise both specialist and traditional medicine, just as non-indigenous people draw on both bio-medicine and complementary medicine. In the next Chapter, I explore some of the outcomes of the emphasis on cultural difference described here, and suggest ways in which these have had an impact on the range of interventions available for Aboriginal people with alcohol problems.

## CHAPTER SIX

---

### Broadening the range of interventions

*In the discussion so far I have shown that the indigenous rights movement launched a process of cultural reclamation among Aboriginal and Torres Strait Islander people. This process included the creation of special links between indigenous people in Australia and other Fourth World peoples, particularly in North America. I also showed that indigenous people in Australia place great emphasis on their relationship with the Federal government, rather than those of the States and Territories, and that they sought direct financial arrangements with the Federal government, particularly in the funding of separate Aboriginal health services and other programs. Government policy-makers and program planners, however, found it difficult to manage the separatist ethos and emphasis on cultural relativity espoused by many Aboriginal health activists, and as a result significant lacunae developed in the national coverage of indigenous health and substance abuse matters. I have argued that in Aboriginal efforts to promote cultural sensitivity, culture itself has become reified, exaggerating the notion of 'difference' between indigenous and non-indigenous people. This became manifested in the development of official portrayals of the Aboriginal - as opposed to other - definitions and understandings of what 'health' means. The stress on cultural relativity and the availability of separate, direct Federal funding made it possible for Aboriginal alcohol programs to develop relatively independently, which had the effect of insulating them somewhat from a changing climate of opinion in Australia about broader approaches to alcohol problems. At an early stage in their development, alcohol programs for Aboriginal people also were largely ideologically and physically separated from community-controlled health services for Aboriginal people. I argue that this separation, as well as the separation of alcohol programs from other, mainstream programs, made the dissemination of broader perspectives more difficult. This insulation, and the charismatic leadership of Aboriginal alcohol treatment providers, led to an antipathy to national policy directives such as harm minimisation, and to a continued reliance on*

*late-stage, tertiary treatment of alcohol dependence, usually in concert with a single-minded valorisation of the disease metaphor of alcoholism. These tendencies were reinforced as a result of the influence of indigenous treatment activists from Canada. The over-riding concern of Aboriginal alcohol program managers, however, has been to provide Aboriginal-controlled and culturally appropriate encounters for individuals seeking help. In this chapter I want to pursue some additional approaches which have been neglected as a result of the processes described above.*

*Utilising the results of a series of research studies I and others have undertaken, I will first discuss the need for (and lack of) secondary prevention activities, which are those interventions which should take place once problems become apparent, but before they become entrenched. I then put forward some propositions about the role of health professionals - particularly doctors - in secondary prevention activities, and discuss the relative advantages and disadvantages of such a focus on health problems in attempts to dissuade Aboriginal drinkers from over-consumption.*

## **1. The broadening of approaches for the general population**

The broadening range of approaches to alcohol problems for the general population which has taken place since the 1980s rests to some extent on the recognition that alcohol consumption (and associated problems) exist along a continuum - from no or light consumption through to heavy consumption, from no problems through to substantial or serious problems. This in turn has led to the development of definitions of 'hazardous' (consumption likely to result in harm if present drinking pattern persists) and 'harmful' (consumption which causes harm to psychological or physical well-being) drinking habits. The recognition of a continuum of problems is now increasingly echoed in the realisation that there should be a spectrum of responses to different degrees of risk and harm, from early, primary prevention, through secondary prevention to tertiary specialised treatment. The widespread acceptance of the idea that - as with other health problems such as elevated blood pressure, obesity and heart disease - alcohol problems range along a continuum, and

that individuals move back and forth along this continuum, has contributed to the gradual demise of the disease model and reductionist views of alcoholism (Anderson 1993, p.264; Donovan 1988). This change of orientation in approaches to alcohol problems mirrors the process of decentering the old, narrow definitions of 'health' and 'disease'.

Further, since the 1980s there has been accumulating evidence that no single treatment approach is effective for everyone with alcohol problems (Institute of Medicine 1990) and that brief interventions can be quite effective (and cost effective) for certain types of drinker when compared with more intensive treatments (Ashley and Rankin 1988; Babor and Grant 1992; Bien, Miller, and Tonigan 1993; Fleming 1997; Wallace, Cutler, and Haines 1988). Research at the Royal Prince Alfred Hospital in Sydney, for example, found that screening for harmful drinking using a ten point questionnaire, five minutes of advice and an information leaflet led to a sustained reduction in alcohol intake. A 40-minute counselling session and a more detailed manual produced even better results (Saunders reported in *Australian Doctor* 1996). 'Brief interventions' is the term used to describe a range of strategies such as screening and brief advice; brief advice and provision of written material; brief motivational interviewing; information or referral to specialist support; and counselling in skills such as relapse management. Typically, a brief intervention consists of about five minutes of interaction between a doctor (or other health professional) and a patient. It usually takes the form of an assessment of the patient's current drinking and the provision of simple advice on health risks and safe consumption. A brief motivational intervention will include assessment of the patient's readiness to change, by encouraging him or her to suggest the good and not so good things about their drinking: 'most things have two sides to them, including drinking' (Prochaska and Di Clemente 1986; Rollnick and Bell 1991). Open-ended questions (rather than judgemental comments) are encouraged, such as 'how would you describe yourself when you drink?' or 'what sort of a drinker are you?'. The patient is encouraged to convince him or her self that the 'cons' of drinking outweigh the 'pros', rather than having a view imposed on them by the health professional. Training in these approaches is often conducted by peers (doctors training other doctors)<sup>1</sup>. As Gossop

<sup>1</sup> In 1995 I was able to observe GP training sessions in Sydney, which were conducted by Dr Colin Mendelsohn (National Trainer for Alcoholscreen based at the Department of Community Medicine, University of NSW).

and Grant note in a WHO publication, these initiatives constitute both 'early prevention' and 'early treatment' which together comprise 'early intervention'. Successful prevention 'decreases the demands on treatment services to a level where scarce resources can be concentrated on the most important tasks' (Gossop and Grant 1990, p.42). In addition, it has been found that brief intervention is preferable to waiting for treatment, and that referrals to more intensive treatment or counselling are often unsuccessful - very few patients follow up on advice to seek treatment (Bien, Miller, and Tonigan 1993).

These interventions can be undertaken by general practitioners, nurses, and a range of allied health professionals; because of their non-specialist nature they have been associated with the continued emphasis on primary health care and population health approaches (Anderson 1996; Higgins-Biddle and Babor 1996). The WHO not only endorses their use but also coordinated a ten-centre cross-national trial of the technique.<sup>2</sup> In April 1999 an American organisation, the US National Institute on Alcohol Abuse and Alcoholism, a major clearing house for information, published an edition of its bulletin *Alcohol Alert* on brief interventions (National Institute on Alcohol Abuse and Alcoholism 1999). The approaches are cost effective, and are democratic in that they are based on the principle that clients have a right to information, and to make choices. The advice given should be non-judgemental, factual, and sensitive. The research literature endorses the view of the potential for screening and brief interventions to reduce alcohol harm among people who are drinking hazardously but are not dependent drinkers (Higgins-Biddle and Babor 1996; Mattick and Jarvis 1994a).

## **2. The missing link in indigenous programs: secondary prevention**

Prevention efforts directed specifically for indigenous people are clustered at the extremities of the intervention spectrum: primary prevention, and tertiary treatment. Primary prevention has focused on education and health promotion using Aboriginal media, local campaigns and the use of community health workers (Frape et al. 1988; Maher and Tilton 1994; Spark,

---

<sup>2</sup> This came about as a result of a 1980 WHO Expert Committee report which stressed the need for efficient methods to detect individuals with harmful alcohol consumption before the consequences became pronounced; WHO called for strategies that could be applied in primary health care settings (Babor 1994).

Donovan, and Howat 1991) These approaches were particularly energetic in Alice Springs where Aboriginal organisations collaborated in a 'Beat the Grog' campaign in the mid 1980s. Prevention activities also focus on controlling the supply of alcohol. This has taken several forms including declaring certain locations 'dry', amending licensing regulations in order to restrict sales to certain categories of people, to rationing the number and type of beverages purchased, preventing take-away sales, and preventing the granting and reissuing of licenses (d'Abbs, Togni, and Crundall 1996; Lyon 1991; Race Discrimination Commissioner 1995). Other preventive programs now in place in small towns and remote communities include the use of night patrols, in which groups of mature-age people, often older women, patrol the streets and intercept illegal drinking, defuse fights, and call the police when things get too troublesome (Mosey 1994). Sobering up shelters in towns have also been an important part of responses to heavy drinking; they serve as an alternative to the police cells for people apprehended while intoxicated and, in the light of Aboriginal deaths in police custody, they function as a harm minimisation strategy. Shelter staff engage in 'brief interventions' of a sort, by offering inmates advice or referral. There are also dry camps which have been established in the bush, alcohol-free events, and in some parts of the country, a growing number of public actions have taken place by Aboriginal people - marches, demonstrations and speeches outside liquor outlets.<sup>3</sup> Women play a significant role in public demonstrations of this sort, legitimating their outspokenness by emphasising their roles as mothers and grandmothers and their concern about future generations. By stressing these socially acceptable aims, they have been able to express what would once have been unacceptably critical opinions.

At the other end of the scale, tertiary prevention or 'treatment' for indigenous people is provided by residential 'rehabilitation' centres, utilised by individuals referred at a late stage in their drinking career. The need for long-term residential treatment for particular sub-groups of dependent people is well established in the literature. These include people with severe alcohol-related brain damage who cannot function independently, those

---

<sup>3</sup> In 1988 several dozen non-drinkers physically destroyed the beer canteen at a Top End community, an action led by Aboriginal health workers. In July 1990, 300 Western Desert women marched to Curtin Springs, a licensed roadhouse on the fringes of Pitjantjatjara land and made speeches outside the pub. In April 1993 there was an Aboriginal anti-alcohol march through Alice Springs which was widely publicised.

experiencing social deterioration who require shelter for humanitarian reasons, and those whose home environment cannot support non-drinking (Mattick and Jarvis 1994b). Many long-term drinkers who are Aboriginal fall into these categories. In 1997-98 \$17.3 million was spent on the Substance Misuse Program of the Office of Aboriginal and Torres Strait Islander Health in the Commonwealth, which funds 61 services providing education and prevention, treatment and rehabilitation.<sup>4</sup> Of these, 26 are residential rehabilitation/treatment centres.<sup>5</sup> In 1998 approximately 50 percent of the overall indigenous-specific drug and alcohol funding was directed into residential treatment services (Commonwealth Department of Health and Family Services 1998, p.84, 134); this is a smaller proportion than it was in 1996 when it was reported that 74 percent of the total went to treatment (Office of Evaluation and Audit 1996).

Apart from consuming a large proportion of the overall budget, these Aboriginal residential programs are comparatively expensive. A review of long-term residential treatment across Australia found that the average annual expenditure per residential place was highest for Aboriginal programs (Ernst and Young 1996, p.110). Finally, as mentioned previously, it seems that Aboriginal and Torres Strait Islander people are also *more likely* to be receiving residential forms of treatment than are non-Aboriginal Australians (Chen, Mattick, and Baillie 1993; Torres et al. 1995). A Quality Assurance Project committee observed in 1993 that their services needed to provide ‘a greater quality and diversity of treatment options ... it appears that one model of treatment tends to dominate the current services’(Mattick and Jarvis 1993, p.222).

What is missing from this series of interventions is evidence of any sustained and informed provision of secondary prevention for Aboriginal clients, in which health professionals or other service providers offer information, advice or physical examinations oriented to alcohol use. The possibilities include screening, simple advice, motivational interviewing, personalising the health effects of excess drinking, testing for biological markers of alcohol

---

<sup>4</sup> This sum does not include services provided by the states/territories, as services may receive funding from a range of bodies. Allocations vary substantially between states.

<sup>5</sup> This is the 1999 figure for residential services funded by the Commonwealth Office of Aboriginal and Torres Strait Islander Health.

abuse, skills training and relapse prevention. In short, a situation has developed in which Aboriginal people have available to them only a limited array of treatment styles.

These findings stand in sharp contrast to the orientation urged by influential drug and alcohol treatment researchers and international organisations. William Miller (among others) has warned against the zealous adherence to any single treatment approach, which he says not only limits the range of individuals who can receive help with their drinking, but is not scientifically justified (Miller 1991). In 1990, the US Institute of Medicine published a seminal report which was the result of a wide-ranging and thoughtful review of all aspects of the 'treatment' of alcohol problems in the United States, and which drew on data from elsewhere. The IOM committee offered a vision of a multi-faceted effort in alcohol misuse which included both community-wide and specialised approaches. The emphasis of this review is reflected in its title: *Broadening the Base of Treatment for Alcohol Problems* (Institute of Medicine 1990). The committee stated unequivocally that early intervention/secondary prevention should be considered as elements in the 'continuum of treatment services that should be available in each community to all persons who need them' (Institute of Medicine 1990, p.46). The IOM gave strong support for brief interventions: 'The role of community agencies in treatment', it states, 'would include the identification of individuals with alcohol problems, the provision of brief interventions to a portion of those identified, and the referral of others to specialised treatment' (Institute of Medicine 1990, p.6). Similarly, in its 1997 World Health Report, the WHO also provided encouragement for secondary prevention:

*Detection of hazardous drinking in primary care and early intervention have proved both effective and low-cost, both in developing and developed countries, and this is one of the most promising areas for secondary prevention of alcohol-related problems, although such simple interventions are insufficient for those patients who are more damaged, or have an established dependence(Director-General WHO 1997, p.62).*

Apart from these authoritative international reports, there is domestic Aboriginal support for broader, and earlier, interventions on an individual basis (rather than simply wide-scale prevention/educational campaigns). Two influential reports have recommended that earlier interventions should be taking place. Although the overall coverage of alcohol issues in the National Aboriginal Health Strategy is somewhat contradictory (see Chapter Three) the working party's report suggested that the staff of Aboriginal health services and other associated organisations should be 'provided with adequate and appropriate education to equip them to deal with people with problems of addiction' (National Aboriginal Health Strategy Working Party 1989, p.203). The other major report which refers to these matters is the Final Report of the Royal Commission into Aboriginal Deaths in Custody, and this makes the more specific recommendation that:

*... the possibility of establishing early intervention programs in Aboriginal health services and in hospitals and community health centres with a high proportion of Aboriginal patients be investigated. This would include the training needs of staff in intervention techniques (Johnston 1991, recommendation 283).*

### **3. The use of brief interventions in Australia**

Australian researchers have been intimately involved in investigations into the use of these secondary prevention activities, which means that the topic of brief interventions is prominent in journals, public debate and conference discussion in this country. Sydney was one of the centres selected for the WHO cross-national trial (Saunders et al. 1993). Some of the world's key investigators of brief interventions are based in Australia. The Quality Assurance Review of the treatment of drug dependence (undertaken by researchers at the National Drug and Alcohol Research Centre, University of New South Wales) recommended that screening and detection of excessive drinkers and early interventions should be promoted in as many primary health care and other settings as possible 'as a matter of urgency' (Mattick and Jarvis 1993, p.149). Nevertheless, the dissemination and use of brief interventions has only gathered pace comparatively recently in Australia. The reasons for slow development in the use of brief interventions for the population as a whole

lie partly in the expected lag between research findings, policy and practice, and partly because of the resistance of general practitioners, who are known to find alcohol consumption a difficult issue to raise during consultations. Other barriers which have been identified include lack of knowledge and skills on the part of practitioners, pessimistic expectations regarding outcomes, and logistical constraints particularly time and the lack of financial incentives (Major 1994; Wutzke, Gomel, and Donovan 1998). In these respects, Australian general practitioners are no different to those in other developed countries.

There has been an even greater lag in the implementation of the various versions of brief interventions with Aboriginal clients. Until the mid 1990s they were little known and rarely used among this population group. This is despite the fact that Aboriginal people were recruited into the Darwin satellite project of the WHO brief intervention trial. Their response was similar to that of the other subjects, although this has never been formally published because of the small numbers of Aboriginal people recruited.<sup>6</sup>

While it is not possible to estimate precisely how many general practitioners in Australia have been trained in, or are now using, brief interventions, examples of the dissemination of brief interventions include the 'Alcoholscreen' and 'Drinking Detective' programs which have trained general practitioners in several Divisions of General Practice in New South Wales (Richmond et al. 1998). In Victoria, general practitioners are attending workshops on motivational interviewing and on managing substance misuse. GPs undertaking these training sessions accumulate continuing medical education (CME) points towards their vocational registration with the Royal Australian College of General Practitioners (RACGP).<sup>7</sup> Training grants for GPs can be sought through the Divisions and Project Grants Program of the General Practice Branch in the Department of Human Services and Health. Divisions of General Practice were established in 1992 as part of a strategy to reform general practice. They were designed to address problems of professional isolation and the

<sup>6</sup> Pers.comm.John Saunders 22/7/97.

<sup>7</sup> Participants in the Drinking Detective training in brief interventions provided to GPs in the south-eastern Division of General Practice in Sydney gain 25 practice assessment points for participating in the project. The GP is expected to undertake an audit of 110 consecutive patients (Richmond et al. 1998). In another Division of General Practice in Sydney GPs earned 12 points for each six-hour workshop on early detection and motivational interviewing they attended (Pers.comm Dr Robyn Richmond; Dr Olga Farnill).

increasing fragmentation of general practice. There are approximately 116 Divisions, which are geographically discrete networks of general practitioners, covering an estimated workforce of 19,500 doctors. Divisional projects have focused among other things on increasing the opportunities for general practitioners to screen patients who are at risk for a variety of health problems (Weeks and Bollen 1996). In 1993-4 for example, four projects in New South Wales received grants totalling \$250,000 in order to train practitioners in various forms of brief intervention, controlled drinking, and early intervention (data from General Practice Branch). In Queensland, brief intervention techniques are being disseminated to hospital staff in a project emanating from the Peninsula and Torres Strait Region Health Authority in Cairns. There are several Australian studies of disseminating the interventions, and publications explaining how health professionals might use them (Goldman 1991; Richmond et al. 1998; Roche 1996a; Wutzke, Gomel, and Donovan 1998).<sup>8</sup>

Only scattered information is available on the use of brief interventions with Aboriginal people. The early intervention unit at the Royal Darwin Hospital screens indigenous and non-indigenous patients using the AUDIT (the Alcohol Use Disorder Identification Test) and offers referrals. State-funded health services in Orange, New South Wales;<sup>9</sup> and the Macleay Hastings district health service at Port Macquarie, New South Wales<sup>10</sup> are also offering screening and brief interventions with Aboriginal clients. In Alice Springs, the Aboriginal health service Congress has recently officially endorsed the role of brief interventions in its 1998 Substance Misuse Strategy, which reads as follows:

*Alcohol.*

*The opportunistic use of brief intervention programs by all primary health care workers. Briefly, this involves bringing to a patient's attention whenever possible that there is a link between their presenting problem and substance misuse and then giving the patient a clear message that the particular substance is damaging their health and offering them a referral to a specialist agency for further treatment.*

<sup>8</sup> There are also instructive videos such as one produced by Flinders University (Flinders Media) entitled 'Brief Alcohol Intervention' (Training Health and Educational Media Pty Ltd., Victoria).

<sup>9</sup> Pers.comm. Didi Killen, education officer. The service has introduced the use of the AUDIT screening tool but local Aboriginal health workers were uncomfortable asking Koori patients the AUDIT questions.

*Common presentations include the link between recurrent episodes of acute bronchitis and smoking or the link between dyspepsia and alcohol misuse. Alcohol awareness is best delivered to individuals in the context of clinical treatment. These types of interventions are simple and cost effective (Central Australian Aboriginal Congress 1998:45)<sup>11</sup>*

The extent to which this policy is being put into practice is unknown; no training in the intervention has been offered to these health professionals.<sup>12</sup>

#### **4. The feasibility of brief interventions with Aboriginal drinkers**

Intervening early with drinkers before alcohol-related problems become catastrophic is, of course, the ideal behind the notion of 'brief interventions', and they have been formulated to deal with heavy social - rather than dependent - drinkers. Most studies of their efficacy have excluded clients who fall into the dependent category, including those who require psychiatric referral and those lacking social supports (Chick 1993). Serious alcohol dependence is associated with high mortality rates and frequently requires intensive treatment approaches (Jurd 1994; Mattick and Jarvis 1994a). In order for there to be any possibility of brief interventions being feasible as an approach to use with Aboriginal drinkers, it is important to examine Aboriginal drinking patterns to see whether there are potential clients who fit the 'ideal type'.

##### **4.1. Feasibility: Aboriginal consumption patterns**

At first glance, it would appear that consumption patterns among Aboriginal people would automatically exclude the majority from being suitable for such interventions. We know that

---

<sup>10</sup> Pers.comm. Gaylene Bawden, Coffs Harbour.

<sup>11</sup> The strategy goes on to include the need for effective treatment and rehabilitation; the restriction of alcohol availability; a demand for continuation of the levy on alcohol; and an evaluation of the success or otherwise of Aboriginal social (licensed) clubs.

<sup>12</sup> In 1999 the first training video aimed at indigenous clients was released. 'Brief Intervention: Counselling for Aboriginal and Torres Strait Islander People' was produced by the University of Newcastle and the National Centre for Education and Training on Addiction, and is available through Training Health and Educational Media Pty Ltd., Victoria.

of those Aboriginal people who drink alcohol, about 82% are doing so at hazardous or harmful levels. We know that bingeing (more than eight drinks on any one occasion) is a major distinguishing feature of Aboriginal drinking styles.

However, Aboriginal people are much more likely than the general population to be ex-drinkers (Blignault and Ryder 1997). Some surveys report between one third and one quarter of Aboriginal people as being ex-drinkers (Blignault and Ryder 1997; Hunter 1993). In the 1970s Max Kamien found more Aboriginal than non-Aboriginal recovered problem drinkers in Bourke. He thought that the prognosis for sobriety in Aboriginal problem drinkers was better than that for whites (Kamien 1978, p.158).

Despite the prevalence of disastrously high consumption in some regions, several studies also provide evidence of 'moderate' or 'responsible' intake. In 1988 Peter Lake, a doctor with the Aboriginal health service in Adelaide, surveyed 102 consecutive patients of the service and found that 'while a good proportion of the patients in this study had advanced alcohol problems, others were good candidates for early intervention' (Lake 1989, p.21). A survey of NSW towns categorised about 20 percent of Aboriginal men and 10 percent of Aboriginal women as 'responsible drinkers' (Perkins et al. 1994). In addition, some years ago researchers found a potential window of opportunity for secondary prevention with Aboriginal clients. Collecting some very interesting information in the form of drinking histories from patients in a detox unit at Rozelle Hospital in Sydney, Chegwidden and Flaherty found that the Aboriginal clients in their sample had begun to drink to excess more quickly than had the non-Aborigines but that there was an average of between three and four years of moderate drinking before excessive drinking began. 'Moderate drinking was followed by an average period of excessive intake of alcohol for 15.3 years before admission to the unit' (Chegwidden and Flaherty 1977, p.700).

To sum up, in terms of the relationship between Aboriginal drinking patterns and the feasibility of secondary prevention, several factors emerge. While there is extremely high consumption, there is also a significant proportion of abstinent individuals in the indigenous population who were once heavy consumers, and this proportion is greater than in the

majority population. The existence of an interim period of moderate drinking among some Aboriginal drinkers, as well as the fact that a proportion of regular drinkers consume in non-dependent ways, means that - notwithstanding the overall prevalence of heavy consumption - there are at least some Aboriginal people who would conform to the 'ideal type' of individual for whom a brief intervention (one of the key platforms of secondary prevention) is thought to be most appropriate.

#### **4.2. Feasibility: brief interventions and other minority populations**

There are no randomised controlled trials of the efficacy of brief interventions with Aboriginal people in Australia. However, results of the WHO multi-centre collaborative project on the early detection of harmful alcohol consumption *suggest* that the intervention may be effective in a cross-cultural or indigenous setting. Of the 10 countries which hosted the trial, three (Kenya, Zimbabwe and Mexico) showed patterns of heavy episodic drinking which are comparable to Aboriginal drinking styles in this country.<sup>13</sup> They also had the highest prevalence of dependence. Both intervention and control groups in these countries showed a reduction in consumption, although equivocally, not all of this could be attributed to the effect of the intervention (Babor and Grant 1992; Saunders et al. 1993). The composite findings for all ten sites were 'encouraging'. Additional published commentary on the cross-cultural applicability of screening and brief interventions include Gureje and colleagues who observe that substantial cultural differences exist worldwide in the way people understand the core concepts used in assessment and diagnosis (Gureje et al. 1997).

<sup>14</sup> However Volk et al (1997) found the screening instrument AUDIT, which is often used in conjunction with brief interventions, showed a lack of cultural bias when tested with different ethnic groups.

It can be argued that health professionals have a responsibility to inform *all* their clients

<sup>13</sup> In Nairobi and Harare, patients in the study drank an average of ten standard drinks per drinking day.

<sup>14</sup> For example the idea of 'counting' drinks was found to be a decidedly Anglo-Saxon concept, alien to respondents in Spain, Greece, Romania and Nigeria. In Korea 'intoxication' denotes a state just short of coma. However the concept of indicators of problematic use is recognised across the cultures studied (Gureje et al. 1997).

(whatever their racial or ethnic background) of the risks associated with consuming harmful quantities of alcohol, and that it is of benefit for any individual already experiencing some alcohol-related social or physical ill-effects to receive help in order to try to ameliorate these. If one accepts these arguments, there seems to be no reason to exclude Aboriginal people from receiving such interventions. In conclusion, there are indications that brief interventions are feasible with Aboriginal clients. While the majority of Aboriginal drinkers consume harmful amounts, and many of these individuals are undoubtedly dependent on alcohol, there is a number who drink heavily who could be amenable to change. The scanty evidence available to us suggests that brief interventions are as persuasive with people from developing countries in which heavy and binge drinking are the norm, as they are with developed English-speaking countries. In addition, there are a few existing examples of health services in Australia which are encouraging their staff to provide screening and brief interventions with Aboriginal clients.

#### **4.3. Feasibility issues associated with cultural appropriateness**

I now want to consider the proposition that advice-giving (and by implication the use of brief interventions) on alcohol, harm and health, is feasible and culturally appropriate for indigenous clients. In order to do so, I draw on a study of the implementation of brief interventions in an Aboriginal community-controlled health service in Adelaide, Nunkuwarrin Yunti,<sup>15</sup> as well as the work of other researchers.

The term ‘culturally appropriate’ is both much-used and ill-defined; it has become a widely-used trope, however, in both indigenous and government discourse (Johnston 1991; Peterson 1999; Sibthorpe 1988; Westermeyer 1981). It has particular currency in the area of health service delivery. Despite problems with the term, its widespread use requires us to come to terms with it and it is probably true to say that the term is broad enough to allow for a number of attributions and applications. I believe that cultural appropriateness as a concept includes notions of respectfulness, sensitivity and flexibility. It implies a recognition that

---

<sup>15</sup> This study was conducted in 1997-1998 in conjunction with the National Centre for Epidemiology and Population Health, the National Drug and Alcohol Research Centre, and Nunkuwarrin Yunti with NH and MRC funding.

indigenous people in different contexts and with different histories carry with them different social behaviours and constraints which affect interactions with outsiders, whoever they may be. Until recently, it has been largely the Aboriginal-run residential rehabilitation centres treating problem drinkers which have claimed to be culturally appropriate. The fact that they are Aboriginal-run centres, with governing boards or committees comprising local Aboriginal representatives, has reinforced this. As already discussed, managers of these centres have asserted that their programs are culturally appropriate because they employ ex-drinkers who are Aboriginal, and because they take cognisance of 'spiritual' and 'cultural' elements of Aboriginal society. Some have built into their program 'cultural' activities such as bush and hunting trips, artefact-making and painting. Some have Aboriginalised the 12 steps, translating them into Aboriginal colloquial English. In many ways, proponents of the residential model of treatment (and its accompanying disease metaphor) have captured the hearts and minds of indigenous people. This is because they have located these programs philosophically within a context of cultural and spiritual revitalisation, and because residential programs have been conceptualised as being the most appropriate venue for the incorporation of traditional values.

In order for the type of secondary prevention which is encapsulated by the term 'brief interventions' to gain any credibility as a culturally appropriate approach, we need to assess the characteristics of interactions between a primary health care practitioner and an Aboriginal patient with the needs of the patient in mind. We would need to demonstrate that these are in keeping with Aboriginal ways of understanding their social world, and with Aboriginal life experiences. One way of doing this is to propose that the Aboriginal patient with an incipient or real alcohol problem has a number of needs which should be recognised by the practitioner if that patient is to be treated with cultural sensitivity.

- The need for private and trustworthy advice
- The need for assessment and evidence of harm
- The need for respect and recognition of individual autonomy
- The need to legitimate personal behaviour change

I discuss each one in turn.

#### 4.3.1. The need for private and trustworthy advice

The use and misuse of alcohol is a problematic subject for Aboriginal people, not the least because of its role in the history of the demonisation of indigenous people and their consistently ‘bad press’ (Langton 1993). The high degree of population-wide, as well as individual, sensitivity is one very good reason why privacy is important in interactions about alcohol. Elements of this ‘privacy’ extend to the situation within Aboriginal communities themselves, where it is not usually acceptable behaviour to directly confront individuals publicly with their problematic drinking activities. In some parts of the country, there may be intra-Aboriginal ritualised harangues about drinking behaviour *in general* but these are often de-personalised and oblique in nature (Brady and Palmer 1984). It is well-established that virtually all residential rehabilitation centres utilise group meetings (both AA and others) which may involve speaking in front of strangers, and many utilise public confessional or confrontational strategies, which can present problems for some indigenous clients. In this context, it is worth mentioning that there is no tradition in Aboriginal Australia of group encounter-healing sessions (as is the case in some other societies).<sup>16</sup> By way of contrast to attending a designated alcohol-related program or unit, consulting a health professional in a health centre or surgery is private in that no-one knows what ailments are discussed in the privacy of the consultation. This arguably makes such an interchange more appropriate with people for whom confrontation is at odds with the ‘character of the culture’. William Miller has endorsed this proposition in the context of approaches to Navajo drinkers in the southwest of the United States. He observed that many Navajo students and colleagues had endorsed in principle the idea that the one-to-one, non-

---

<sup>16</sup> For example North American healing traditions which utilise sweat lodges, shaking tent, and other techniques are essentially group events, albeit with expert practitioners (Jilek 1988; Johnson 1990; Vogel 1990); the Kalahari Kung - hunter-gatherers like Aboriginal Australians - practice a community-based ritual healing dance including laying on hands (Katz 1982). In this context, it is remarkable that no-one has pointed out that the group sessions which are ubiquitous at Aboriginal rehabilitation centres bear little resemblance to any ‘traditional’ healing framework, despite claims that these programs are based on Aboriginal cultural and spiritual practices.

invasive approach of motivational interviewing (for example) ought to be highly culturally compatible.<sup>17</sup>

As with any patient, the Aboriginal patient needs (and has a right to) honest personalised advice about the effects of his or her alcohol consumption. An Aboriginal patient, like others, is usually interested in matters concerning his or her own body, and the risk of any damage to it - and there is some evidence to support this contention, which is discussed below. Among remote-dwelling people, and others who frequently engage in the hunting and butchering of wild game, Aboriginal people are knowledgeable about anatomy. They are familiar, for example, with organs such as the liver and the kidneys<sup>18</sup> and with the features of healthy organs such as these.<sup>19</sup> This may help some Aboriginal people in discussions of alcohol-related harm to the internal organs.<sup>20</sup>

As a result of their training and expertise, doctors in particular are known to have esoteric skills in 'reading' the body and its symptoms; they can 'look inside' the body in a special way. The delivery of a brief intervention can be prompted either by the nature of the presenting problem, or by the discovery, by means of screening or assessment, of hazardous or harmful use. Either way, the health professional can take the opportunity - the 'teachable moment' - legitimately to raise alcohol consumption for discussion with the patient. However, the complexity and number of health problems presented by Aboriginal patients can be enough to push an exploration of alcohol use into the background. In view of this, the presence of a tangible alcohol-related presenting problem may be necessary in order to persuade a doctor to raise the issue of alcohol (as well as in order to persuade the drinker to

---

<sup>17</sup> Pers. comm. William Miller 30/3/95.

<sup>18</sup> Anecdotal information from long-term Aboriginal drug and alcohol workers suggests that some clients are impressed by being shown specimens of preserved diseased livers. Two individuals (Jack Little from Bulla, Northern Territory, and Cyril Coaby from Ceduna, South Australia), both stressed the power of this tangible teaching tool. In an interview, Little expressed it thus: 'A lot of people, they like to see something in front of their natural eye - because they cannot understand. When we try to educate our people, pretty hard for them to believe sometimes'.

<sup>19</sup> An Aboriginal health worker from Victoria observed however, that many long-term drinkers are pessimistic about the state of their physical health, with one patient telling her 'my liver's dead' (Fieldwork notes 25/5/95 Victorian Aboriginal Health Service).

<sup>20</sup> This factor may not be so relevant to urban people who may not have the opportunity, the inclination, or the knowledge to engage in hunting activities.

do something about it). For example, a District Medical Officer (DMO) working at Bagot in the Northern Territory observed,

*There was not the time to target every 'drinker' but there were a few occasions where, at the request of an Aboriginal Health Worker, the time thus spent was very beneficial. One such instance was that of a 19 year old who had recently been admitted to Royal Darwin with an alcohol induced cardiomyopathy. His outlook was very poor if he did not stop drinking and he was only expected to live for a very short time if he did not become completely abstinent. He had strong pressure to drink alcohol from his peers, but, after explaining the serious health effects of his condition, he managed to become abstinent and remain that way. He set a powerful example to his community and became a key worker for his community. I had a good relationship with his family and I think that helped to a great extent (K.E.)*

#### **4.3.2. The need for assessment and evidence of harm**

There are now a number of biological markers of excess alcohol use which may be used, and Anderson (1996) and Higgins-Biddle and Babor (1996) have highlighted the usefulness of these tests both in screening and as interventions in themselves. Serum Gamma GT (GGT) is the most widely known test for excessive alcohol use, with this liver enzyme being elevated in 60-80 percent of alcoholics (Mattick and Jarvis 1993, p.136; Salaspuro 1994). However other conditions such as non-alcoholic liver disease may also cause elevated levels. One advantage of using the GGT with Aboriginal patients is that with the use of a portable Reflotron machine, tests can be processed and results given to the patient immediately. The carbohydrate-deficient transferring test (CDT) is a relatively new hematological state marker which has been found to be highly specific (Ballard 1997; Batey and Madsen 1998; Mattick and Jarvis 1993; Salaspuro 1994; Stibler 1991). It is also highly independent of concomitant liver disease. There is evidence that Aboriginal people take a keen interest in obtaining test results that have a bearing on physical damage associated with alcohol. Apart from helping to convince the patient of ill-effects, these have cultural and social utility for indigenous patients.

As an adjunct to personalised verbal advice, the provision of personal test results is said by several commentators to be well-received by Aboriginal patients (Hunter, Hall, and Spargo 1991; Markey 1996). As one Aboriginal health service doctor observed: 'people do generally respond to the idea (of a test). Everybody likes some sort of concrete feedback'. Doctors working in Nhulunbuy, Northern Territory, for example, reported positive results from a needs assessment of about four hundred Aboriginal people living in the East Arnhemland region in 1994. The health service undertook blood pressures, blood sugars and a health review including a detailed history of drug and alcohol use, and provided immediate personalised advice and feedback of results. They found that at a two-year follow-up, significant numbers of Aborigines had decreased their alcohol consumption as a result of the advice and test results they received<sup>21</sup>. During our study at Nunkuwarrin Yunti, in 1998, the health service (in central Adelaide) held an open day in which members of the community were invited to look around, talk to health workers, and undergo free health checks. The study team had provided the service with a Reflotron machine which provides instant test results. On that day 8 women and 20 men volunteered to have health checks, with tests for GGT, blood pressure, and diabetes. Results were written down for those individuals. The GGT tests showed three individuals with high readings who were referred to a doctor. According to the health workers, the exercise provoked much discussion and interest.

I propose that there are several factors which make the provision of test results particularly pertinent for Aboriginal patients. First, it is clear that many Aboriginal drinkers consider their intake to be acceptable despite the fact that it is often catastrophically high by any standard. Aboriginal drinkers have a high level of tolerance for the social and physical ill-effects of their use, which is reinforced by the coexistence of high levels of tolerance for abusive drinking within the Aboriginal community generally. In other words, heavy drinking has become normalised. Because of this drinkers need to be convinced that their intake is physically damaging, or has the potential for damage, especially if they have not

---

<sup>21</sup> Pers. comm Dr John Fraser and Dr Elizabeth Chalmers, Miwatj Aboriginal Medical Corporation.

yet experienced specific alcohol-related symptoms or had the link made for them between experienced physical symptoms and alcohol consumption<sup>22</sup>.

Second, biological markers for alcohol abuse provide tangible, factual proof of physical damage, which can assist in the process of convincing the individual concerned. This is particularly necessary because of existing low levels of knowledge about the damaging effects of heavy consumption which are sometimes compounded by poor levels of education and literacy. Third, because they are subjected to such intensive social pressure to maintain heavy consumption, Aboriginal drinkers need to be provided with external sources of 'proof' of the need to change their consumption patterns. A test result, delivered in a factual and non-accusatory manner by a health professional can supply neutral evidence as legitimation which can be presented to those applying this type of pressure.<sup>23</sup> In summary, while the taking of blood is not a comfortable experience for any patient, the feedback of results can be used by Aboriginal patients in ways which assist them to deal with their drinking partners in a culturally appropriate way. The results of such a test enable a drinker to explain his or her decision to absent him or herself from a drinking session, or to refuse an offer of alcohol, in a way which de-personalises the decision, makes it non-negotiable, and which can be expressed to others without rancour. All of these are highly relevant to the social circumstances within which Aboriginal people conduct their lives.

Despite being aware of the enormity of the underlying poverty and overcrowding affecting Aboriginal people, one doctor thought that providing evidence of harm was still important:

---

<sup>22</sup> For example, pancreatitis is persuasive in this context, because it is so painful; on the other hand doctors observed that diabetes (which requires strict control of alcohol use) is hard to use as a motivator because the condition does not hurt or make people feel ill until much later in the course of the disease. One doctor described using people's multiple infections to persuade them to stop drinking by saying that the alcohol is 'killing their cells'. He attempts to be honest while not exaggerating the dangers, in order to avoid the disbelief of patients. An experienced nursing sister observed that some symptoms become 'conventional wisdom' as acceptable indicators of the need to give up drinking: at Yalata, in South Australia, blood pressure has been taken up by Aboriginal people as a reason to give up, whereas diabetes has not.

<sup>23</sup> These tests are not only conducted in order to detect alcohol-related damage. Liver function tests are indicated in a variety of other conditions which may affect Aboriginal people. For example both prophylactic TB treatment and chronic ringworm treatments affect the liver, and so liver function tests are done before people begin medication. Alcohol related liver damage can be picked up inadvertently in these cases.

*...there is always a place to diagnose alcohol problems, personalise the health effects for each individual by feeding back results of high blood pressure, liver enlargement, abnormal liver function test, peripheral neuropathy, depressed immune system, depression, or whatever the sickness is. It is also equally important to try to give some positives to balance up this usually depressing and unsettling feedback. This is difficult and needs to be part of the community approach to such problems. It may consist of referral to a culturally appropriate agency, follow up on a regular basis at the clinic, additional support from the family, health workers or other community members. All this needs to be done after assessing the client's readiness to change. If the client is not ready, I feel some sort of motivational interviewing, weighing up the pros and cons of drinking behaviour in a personalised way, may be appropriate for some people. A need to be non-confrontational and supportive is also crucial (K.E.)*

#### **4.3.3. The need for respect and recognition of individual autonomy**

Another feature of social and cultural life which is pertinent to this discussion of the provision of secondary prevention and the needs of Aboriginal patients in these interactions, revolves around the issue of personal autonomy. Because discussions about alcohol consumption will inevitably involve some advice-giving (even if they are couched in the techniques of motivational interviewing), and because any health intervention carries with it the implication that the client will *consent* to change his or her behaviour, it is important to recognise the importance of Aboriginal notions of autonomy. Personal autonomy is highly valued among Aboriginal people across all regions of Australia, although it is perhaps more fiercely adhered to in particular areas. I showed in Chapter Five how this individual independence of spirit can facilitate dysfunctional drinking

It is significant that numerous self-quitting individuals interviewed recalled the influence of an outside health professional in their decision, but they were nevertheless emphatic that they had 'done it' on their own: in other words they were the ones who had accepted the problematisation of their drinking and transformed this into action. 'Even though the doctor

tells them, it's up to the person to decide' one woman said. In retrospect, these individuals believed their decision to have been a free choice.<sup>24</sup> Other self-quitters who had not been influenced by a health professional stressed the autonomy of the decision as well.

*Did leave em like that, we never have no white man come and tell us, you know? Anybody come up and tell us 'leave your grog', or other way if somebody come telling me all the time, (in) my life I get sick of people telling me. But I left the grog, got my own, own feeling (B.L.)*

*Even then when I think about it, it makes me shiver to think I actually did it. It really was hard, 'you know? It's hard to explain to anyone what the feeling was, you know it's really hard. Sometime when I think about it, it makes me want to cry because - really it's so unbelievable that I actually done it you know? It's just that I can't believe that I actually did it. A lot of people around Katherine thought I was a Katherine drunk, you know. And I think to myself, and I pinch myself, see - I did it!*

*(S.M.)*

With this ethnographic evidence in mind, it is undoubtedly crucial that a brief intervention of whatever kind not be didactic or authoritarian in its delivery, neither should it be open to interpretations of 'bossing' or interference with an individual's personal freedom ('I get sick of people telling me'). Obviously, this is the case for *any* patient not just an Aboriginal patient, and Rollnick and colleagues have written about the resistance and withdrawal which occurs in the case of attempts at overt persuasion of someone who is not ready to change: what they term 'psychologic reactance' (Rollnick, Heather, and Bell 1992, p.27). However, this resistance may be more pronounced among Aboriginal patients, who have more reason than most other people to be wary of medical encounters.<sup>25</sup>

<sup>24</sup> Prochaska and DiClemente (1986) call this 'self liberation'.

<sup>25</sup> The reasons for suspicion of medical contexts by many Aboriginal people include previous experiences of discrimination, real or imagined racism, dismissive treatment in hospitals and other services, refusal of treatment, and plain discomfort at the encounter with the medical profession.

The fact that brief interventions which utilise motivational interviewing or versions of it (Rollnick and Bell 1991), are oriented to working with the patient's own words, his or her analysis of drinking, and in the end, accepting the individual's decision, are all indicative of the ideal of respect for autonomy which are so important in interchanges with indigenous clients. The goal is, as Rollnick and colleagues point out, to work with the principle of individual autonomy by encouraging the client to explore his or her ambivalence, and move at a measured pace. It would even be possible to conceive of these non-authoritarian approaches as a form of 'individual' self determination - an expression usually used only in its collective sense. While a health professional can provide options for the patient to think about (such as abstention or techniques for cutting down), it is the individual who makes this self determining choice. Within the variety of brief intervention approaches which may be used, there is no ideological adherence to either abstention or moderation as a goal. Doctors who have had some experience of delivering a brief motivational interview in the Aboriginal health service in Adelaide, offered comments on these non-directive thrust of the intervention and how this reflected cultural sensitivity. A typical brief intervention includes asking the patient to consider the 'good' and 'not so good' things about their drinking, and then to weigh up these aspects of drinking.

*You know I still think it (brief intervention) would be culturally appropriate, because it's supporting the sort of thinking between the 'not so good' and the 'good' things. There's nothing culturally inappropriate there. We are asking the patient what he thinks. It's appropriate in every culture. We're not imposing ideas on them. They don't feel threatened. They don't feel judged (D.C.)*

*There is no difference between asking Aborigines and non-Aborigines about alcohol. I think it (the brief intervention) seems to be culturally appropriate. I don't get the impression that Aboriginal people feel that you're being intrusive ...but there are some people who do feel a bit touchy about it (D.M.)*

*There is a difference (between asking Aborigines and non-Aborigines about drinking). I can ask non-Aboriginals straight how many cans of beer without batting an eyelash or something like that, whereas for the Aboriginals I have to pad it (D.C.)*

*Culturally appropriate? I don't see why not. I think it applies to all people really, doesn't it? (S.N.)*

#### **4.3.4. The need to legitimise personal behaviour change**

If Aboriginal people who are at risk of alcohol-related harm are to change their drinking behaviour, they need good reason to do so. Authoritative evidence and advice from an external source are important for two reasons. They are necessary in order to convince the patient that change is required, and also in order to provide the patient with a legitimate excuse for change, which can be used socially with others who would put pressure on the individual. The need for authoritative evidence of harm is undoubtedly important to anyone attempting to change their behaviour, but it is useful to highlight some reasons why this is particularly important for Aboriginal drinkers.

We know from ethnographic research that there are many difficulties encountered when Aboriginal people attempt to give advice to their peers (Myers 1986; Sackett 1988; Sansom 1980). For example a Pitjantjatjara-speaking man reported that if he said to someone 'Hey! Don't drink, it's killing you!' that this advice 'bounced back' and that he would see that same man drunk the next day. 'I have to leave them to decide' he told me.

The following excerpts from interviews highlight very widely-held views:

*We've got to go our own way you know, own way. If you want to stop drinking, you've got to worry about yourself. See, I can't tell other people to stop drinking, they've got to find out for themselves. After an accident or – that's their lookout. We can't stop people from drinking. That's their life. When we tell people 'you want to*

*stop drinking' they say 'no, that's our life. You can't tell us what to do. That's our problem.' That's what they say. Yeah, a lot of blokes say that. (B.Q.)*

*Can't force people, can't force people to stop drinking. They gotta find out themself. When they get sick or something like that. So I had to do it for myself. They gotta do it for theirself. They got one life. We all got one life. But I can't force them. If they want to drink, they drink. If they want to stop, they can stop. (K.P.)*

*I reckon it's really hard you know for people that can't give up drinking. If we can give up drinking that is good luck, if you don't stop, well, it bad luck. Like that we [counsellors] tell them 'we can't stop you drinking or anything like that, it's your own time because you gotta stop yourself'. (J.N.)*

*If they ask me if I got change (ie. cash) I always tell them 'don't buy too much grog. Please don't drink too much'. But I don't force them to stop drinking or what, you know. Judging them. Its their way of living you know, really (C.R.)*

These statements clearly indicate that if an Aboriginal drinker is to be amenable to persuasion, the persuasion needs to emanate from someone other than a close community member.

The Aboriginal drinker not only needs to convince him or herself that their drinking behaviour should and can change, he or she needs to be able to convince others. In order to do this successfully, the newly-resolved drinker has to provide an *outwardly legitimating excuse* for their change of heart. We know from ethnographic data that when Aboriginal people try to give up drinking, they are forced to draw on a repertoire of explanations and engage in a series of elaborate social reassurances with their peers. Because of the complex requirements within Aboriginal social life to continually reconfirm relatedness by making demands and claims on others (Peterson 1993), and by means of demonstrable acts of giving and receiving, individuals must somehow refuse alcohol without jeopardising their relationship with the other. As Archie Barton explained in his 'giving up' story,

*I think the number one problem with my people is this: until they can accept mates as mates other than being drinking mates, you know, we're going to have no people left. ...they'll tempt you and that's where you show the really strength you know, to say, 'look, I'm still one of you, but I'm not drinking no more' (A.B.)*

Further examples of the convoluted explanations people used include: 'I'm still your friend but I'm not going to touch that drink'; 'I'll drink a coca cola for you'; 'No I can't help you any more with the grog, you can have it by yourself. Buy me a cool drink or something like that, I'll help you'. These statements highlight the way in which accepting the offer of a drink, that is, allowing (or 'helping') someone to buy you a drink, is a means of reaffirming the relationship. The response to an outright refusal (given without such careful elaborations) is often derision and emotional blackmail: 'Trying to be different?'; 'Acting like a white man'; 'You don't love us any more'. For example a Katherine man described how he dealt with this in the pub where he goes to socialise while drinking orange juice:

*If I just walk out, and don't talk to anybody, then Aboriginal way, in our way, if they call out to me and I just walk past, they'll think 'oh, he's a white man' you know. Acting like that white man. I can talk with them, sit down and have a talk, ask them how they're going and sometime ask 'you feel sick from drinking?', you know? One thing you know, you got to stop and talk to them. If I just walk past and they think I'm just walking past - 'oh, you don't drink' - they think it's a white man there you know. 'You don't like us anymore'. Too hard. (C.R.)*

None of this is easy, and many ex-drinkers found that the only solution was to 'cut off' from their former friends. It is clear that in this socially pressured context, more than just willpower is required for an individual to extricate him or herself. A way out of this dilemma is find a face-saving and external legitimation for not drinking. The anthropologist Fred Myers documented how Christianity was used by the Pintupi in this context:

*The effectiveness of Christianity in the context of Pintupi culture is that it provides an authority outside the individual subject on which he or she can base a refusal to participate in drinking. "I can't drink; I'm a Christian" has become an acceptable form of refusal. Former alcoholics articulate their abstinence as adherence to an authority outside themselves (Myers 1986, p.269).*

In summary, many Aboriginal people need a persuasive external referent to whom they can attribute the 'blame' for the need to change or modify drinking behaviour. They require, as Myers suggests, an authority outside themselves.

## **5. Which health professional could best deliver brief interventions?**

According to the propositions I have discussed, secondary prevention in the form of personalised advice is at least feasible with Aboriginal clients. Some have drinking patterns which are thought to be amenable to change; clinical trials in cross-cultural situations have not produced any major barriers; and the interventions seem to dovetail with the needs of patients for privacy, honest assessment, respect for their autonomy and provision of a legitimating excuse. But the question remains as to who should provide this advice. Should brief interventions be delivered by Aboriginal health workers to other Aboriginal people who are patients? Or are doctors in a better position to do so? Much of the literature on brief interventions, particularly that emanating from the WHO multi-centre trial, has stressed that these secondary prevention activities can be undertaken by a *wide range* of primary health care professionals. Other studies have focused primarily on the role of doctors in hospital emergency departments or in general practice.

### **5.1. Early reports of interest in the role of doctors**

Interestingly, there are some early references to the possibility of what we now call brief interventions being undertaken with Aboriginal people by doctors. These can be found in material dating from the 1970s. It appears that these early observations were not acted on in any meaningful way at the level of policy or service-delivery. One example is to be found in

the submission by Congress (the Aboriginal health service in Alice Springs) to the 1977 House of Representatives Standing committee on Aboriginal Affairs enquiry into Aboriginal alcohol problems (HRSCAA). Congress, which had been operating for only eight months at the time, noted that there had been

*...quite a lot of contact with patients with alcohol problems. In general, patients present with alcohol related problems rather than asking for help with their alcoholism. Problems such as traumatic injuries, gastritis, epileptic fits, peripheral neuritis and malnutrition are not uncommon...*

The submission (from Dr Trevor Cutter) observed that the doctors at Congress undertook ‘supportive discussion and advice’ with some patients with alcohol-related problems. The submission continued:

*Although this approach is limited, it has been quite successful in a number of individuals and there are several young and middle aged men, who after discussion have been able to control their drinking problems. These men have in general belonged to the urban and fringe camp groups where there is greater opportunity for effective doctor-patient relationships. The Aboriginal Health service is the only body providing this type of counselling within the town and provides an important service and must be given strong support (HRSCAA 1976-1977, p.1196-7).<sup>26</sup>*

Also at the HRSCAA, the Director of DAA in Western Australia Frank Gore, told the Committee hearings of an Aboriginal he had heard of whose doctor had told him he would be dead within a year unless he stopped drinking. ‘Maybe’, he mused to the Committee,

---

<sup>26</sup> Congress also proposed a multi-faceted program for dealing with alcohol which stressed a non-institutionalised community-based approach. It included a pick-up service, a night shelter, a rehabilitation/refuge centre (the Congress Farm), and proposed linkages with traditional healers (*wadi ngangkari*). They urged that the participants should not be labelled as alcoholics but should be called ‘trainees’. Twenty-two years later, in 1998, Congress officially endorsed the role of doctors and other health staff in early interventions when it endorsed ‘the opportunistic use of brief interventions programs by all primary health care workers’ (CARPA Newsletter 27 March 1998, p.45). Congress included the role of brief interventions in its 1998 ‘Policy on Alcohol’. Despite the 1977 reference to the role of doctors the alcohol policy of that year did not refer to the role of doctors other than as referral agents.

'that technique' is necessary (HRSCAA 1976-1977, p.1690). The other person who mentioned the role of doctors was Max Kamien, a medical practitioner who worked in Bourke, New South Wales in the 1970s (Kamien 1975a; Kamien 1975b; Kamien 1978). He reported to the HRSCAA in 1977 that attempts at treatment for alcohol problems through hospitalisation, individual and group therapy, AA and the use of Antabuse were all unsuccessful. Community education on the health hazards of alcohol 'fell on ground rendered infertile by the low priority that physical well-being occupied in the felt needs of the Aboriginal'. However, the factors which did result in either abstinence or a diminution of alcohol intake were *a poor prognosis delivered by a doctor at the time of an alcohol-induced illness*, a conversion experience, and separation from the primary drinking group - either by geographical distance or by joining another social group such as the church (HRSCAA 1976-1977, p.2740-1).

In addition to these muted references to secondary prevention and the role of doctors in the 1970s, some years later two physicians from the Royal Prince Alfred Hospital drug and alcohol service in Sydney drew attention to the need for a diversification of alcohol services to Aborigines in New South Wales. Harding-Burns and Sullivan observed that the available services placed 'undue emphasis on medium- to long-term residential rehabilitation programs'. They noted that 'other pressing needs such as detection, assessment, detoxification, referral and follow-up remain to be fulfilled'. These clinicians provide case studies which illustrate successful cooperation between a specialised drug and alcohol unit and Aboriginal health workers; the unit undertook early case detection, and the health workers arranged community follow-up which provided contact with support workers and work training. While they do not refer explicitly to 'brief interventions' they stress the need for the active (early) detection of alcohol-related problems and the importance of linking Aboriginal therapists with sources of expert help (Harding Burns and Sullivan 1983).

## 5.2. Evidence of late-stage interventions by doctors

The observations cited above from Dr Trevor Cutter in Alice Springs, and Dr Max Kamien in Bourke both refer to the influence that doctors can have with Aboriginal patients once

their alcohol-related symptoms become manifest. My work with ex-drinkers provides further and more detailed qualitative support for the proposition that doctors can be persuasive, even at a late stage in a patient's drinking career. Between 1992 and 1994 I interviewed 45 adult Aboriginal men and women who had ceased their previous heavy consumption of alcohol<sup>27</sup>. The study was designed to investigate recovery from alcohol problems without formal treatment, an issue that now under scrutiny among different sub-sets of drug and alcohol users in the majority population in different countries (Burman 1997; Humphreys, Moos, and Finney 1995; Klingemann 1991; Sobell, Sobell, and Toneatto 1992; Sobell et al. 1993; Stall 1983; Tucker, Vichinich, and Gladsjo 1994). This process has been variously termed spontaneous remission, natural resolution, spontaneous recovery, and natural recovery. The interviewees were drawn from a number of remote and rural locations in the Northern Territory and South Australia, and were located opportunistically through local alcohol services, community councils and my existing networks. I explained that I was interested in how these individuals became motivated to change their drinking behaviour, in the hope that the information would be of assistance to other Aboriginal people. Interviews were open-ended and free-ranging, although all those I interviewed were asked questions to determine the degree of their alcohol problems.<sup>28</sup>

The men and women interviewed had some interesting comments on the circumstances which caused them to contemplate change. The interviews revealed that doctors and some other health professionals such as nurses were already intervening with many Aboriginal patients who are suffering from serious health problems associated with their drinking. Fourteen individuals specifically recalled that a local or hospital-based doctor (or less often, a nursing sister) had advised them to stop drinking. I found that experiences of, or concern about, ill health and warnings from health professionals were key influences:

<sup>27</sup> The edited narratives of these individuals have been published (Brady 1995a).

<sup>28</sup> These included questions on alcohol-related fits, blackouts, early morning drinking, tremor, and indicators of social problems such as incarceration and loss of employment. All interviews were tape recorded, transcripts of the interviews were returned to each individual and return visits made wherever possible. I compiled the interviews for each community into small booklets which were returned to the communities for their own use; later all were published, once permissions had been obtained and instructions given on the publication of names or pseudonyms for each interviewee.

out of the 45 people interviewed nominated these as primary reasons for the cessation of alcohol consumption. Three more experienced serious trauma in alcohol-related motor vehicle accidents and nominated these as reasons for quitting. This brings the health-related attributed causes to 30 out of 45. Many of these people were impelled to stop drinking out of sheer necessity, or risk death. People did not necessarily take notice of these warnings on the first occasion. Individuals' comments included: 'The doctor gave me a hard talk'; 'The doctor said to me straight "It's your, not my, life"'; 'Doctor told me this is your last chance. If you don't stop, you'll be finished'. People showed faith in these practitioners and many could remember the names of doctors who had spoken to them or treated them years before. Most, however, were suffering very serious alcohol related complications by this stage - people in their late 30s and 40s who had been drinking heavily for 10-15 years. Many interviewees had experienced serious health problems which motivated them to stop.<sup>29</sup> Some of these people asserted that no-one had told them earlier in their drinking careers that alcohol was damaging to their health.<sup>30</sup> The interviews provide qualitative evidence that a) Aboriginal people are concerned about their health and b) doctors can and do have influence even with chronic problem drinkers, at a *late stage* in the development of health problems. The following are excerpts from four of these interviews which highlight the role of doctors (and in one case a doctor and a nursing sister):

*It was in 88 I stopped drinking, on account of my foot. I'm diabetic and more alcohol I drank it sort of infection in my body, and being a diabetic, if you get any cut or anything you sort of break out, infection breaks out. That's what happened to me, and then I went to the hospital and the doctor said to me 'you drink?' and I said yeah, 'But for a start' he said 'stop drinking'. OK I did, that was when I was*

<sup>29</sup> The serious health problems experienced by the interviewees were as follows:

Digestive problems; Hearing dead people's voices; Heart (enlarged/heart attack/bypass cardiomyopathy (5); Diabetes (2); Liver including cirrhosis (6); Ill, short of breath, sick, poor health (3); Tumour removal; Hospitalisation (reason unspecified) (3); Hypertension/blood pressure (3); Fits/fear of death; TB (sanitorium).

<sup>30</sup> Several interviewees also observed that they wanted to tell their stories and that no-one had previously taken an interest in these accounts, of which many were justifiably proud. Judging by the willingness with which people participated in this study, and the positive comments from some interviewees, I concluded that the process of telling me their story of recovery was in itself therapeutic, a point that is also made by researchers in Canada who investigated recovery from alcohol problems without treatment among Canadians (Sobell, Sobell, and Toneatto 1992).

*in hospital...The doctor said to me 'you keep on putting weight and then your sugar going to be high and then if you get any cut or any sores, get infected, you break out' and then I said I just gave up drinking altogether. (L.S.)*

*Then I got a check up. I went to see the doctor and he said, 'oh, you got a blood pressure problem you know, you better stop drinking, because that's the problem: you got to stop smoking, stop drinking'. And I sort of listen to the doctor you know. Some doctor tell the truth, some doctor don't, but this doctor I sort of trusted him and sort of gave it up.' (J.S.)*

*Then I end up in hospital in Ceduna and they had an X-ray of my body. Then the doctor find out what's wrong with me you know. They told me 'you gotta large heart'. Doctor asked me 'you drink a lot?' And I said 'yes'. And the he asked me 'you only young, in your 30s. I'd like to see you stop drinking. It is benefit for your body and for the future as well'. Dr Jolly, he's a doctor. I've got to believe him, he's a doctor. So when I came home to Yalata, I was still weak in my body...I seem to have thrown it away from the time the doctor in Ceduna, and Sister Maria (the nurse) spoke to me. Sister Maria was working at health in Yalata and Oak Valley. She used to tell me to stay strong, don't fall from that road. No one else, only she. And I did' (J.W.)*

*After that I bin go to the doctor with my head no good, dizzy. I went to see doctor, blood pressure. Stop for a little while then drinking again. Doctor told me to stop, I never take any notice. Had Dora then. First was Maxine, first granddaughter, tried to stop from there, first granddaughters. First granddaughter you know, look after her. Finisharingu<sup>31</sup>. I gotta look after all the kid. (H.Q.)*

I also conducted interviews with medical officers working either in an AMS or as State/Territory District Medical Officers regularly visiting rural populations<sup>32</sup>, which

<sup>31</sup> In Pitjantjatjara this is literally 'became finished', ie drinking stopped.

<sup>32</sup> These were medical practitioners working out of Katherine and Darwin, Northern Territory, and Ceduna, South Australia.

provided some limited data about the circumstances under which they *usually* advised their Aboriginal patients to stop drinking. Almost invariably, this advice was given when dictated by medical conditions: if the patient was using particular medication (some antibiotics, post rheumatic fever and TB medication were given as examples); if pregnant; if suffering from serious presenting complaints (heart attacks, pancreatitis, enlarged heart, enlarged liver, overweight or hypertension, diabetes, and multiple episodes of trauma or multiple infections; to qualify for assessment for heart surgery;). Several doctors reported that high blood pressure was a useful presenting problem to use as a means of advising people to stop or moderate their drinking.

It is clear from these data that both medical practitioners and Aboriginal clients are primarily referring to late-stage interventions.

### **5.3. Are doctors the best people to provide secondary prevention?**

Doctors have a number of strengths which point to their potentially influential role as providers of secondary prevention in the form of brief interventions. Overall, at the level of a purely bio-medical model, there is great potential for their role in pointing out for the patient the link between his or her presenting symptoms and the role of alcohol in those symptoms. They can have a role in providing 'proof' to the patient by providing test results of biological markers for alcohol abuse. These are examples of the advantages of *medicalisation*<sup>33</sup>. Despite the critiques of bio-medicine and the medical model, emanating from indigenous and other quarters, researchers working in developing health have pointed out that medicalisation does in fact have value. This is because it serves to increase the self-perception of morbidity (Briceno-Leon 1993, p.293; Murray and Chen 1994, p.103; Reid 1983, p.124). There is potentially a direct effect in increased numbers of individuals being diagnosed with conditions which may not otherwise be perceptible or associated with alcohol abuse (such as hypertension).

---

<sup>33</sup> The wearing of medical bracelets is another example of the use of medicalisation and of external markers as 'proof'. Some vulnerable Aboriginal individuals (for example those taking Antabuse or suffering from alcohol-related brain damage) have been given medical bracelets to wear, which are used by the wearers to signify as well as defend their non-drinking status (Pers. comm. Ernest Hunter).

A doctor also bears the symbolic attributes of one who has the specialised power to heal, attributes which in some ways are comparable to the role of the traditional healer in Aboriginal society. A clinical doctor-patient consultation contains features which mimic the consultations between Aboriginal patients and traditional healers.<sup>34</sup> These are also largely conducted on a one-to-one basis, with an individual seeking out the services of a particular practitioner, and the diagnosis and treatment taking place on a relatively private level. If others are present, they would normally be only close kin. For those Aboriginal people who live in areas where they have access to indigenous traditional healers, this symbolic association may be beneficial.

Another important attribute is that doctors seem - on the whole - to be trusted individuals. There is little published data about Aboriginal attitudes to medical practitioners, but drinking histories collected from Aboriginal people provide indications that considerable trust is placed in doctors (Myers 1986, p.280). Comments from both health workers and medical staff at Nunkuwarrin Yunti reinforced the idea that patients both respect and listen to what doctors say:

*I think people listen to doctors, because I think Aboriginal people have got a thing with doctors. They put them up on a pedestal. Definitely. I think they think doctors are like a god, I think they do. If you go to the doctor and the doctor tells you what's wrong with you, he can tell you something different that's wrong...he can tell you 'Look you've got this heart murmur there' or 'Your heart's enlarged'. You're going to listen to him before you listen to a nurse or your mother or anybody else like that, eh, because he is a doctor. He knows. They're supposed to be there to help you. They're there to help you. They're supposed to know what - Their job's there to tell*

---

<sup>34</sup> It is not possible to estimate the extent of contemporary use of traditional healers, known variously as *ngangkari* (Pitjantjatjara); *marrnggitj* (Yolngu-matha); *mabarn* (in the Kimberley, western desert regions of Western Australia), however their services are sought in several regions of Northern and Central Australia. They use a range of herbal remedies and deep pressure massage. They are credited with the expulsion of foreign bodies or harmful spirit beings which are held to be the cause of internal pains and illness. Traditional healers may also 'sing' a patient, using excerpts from secret song-cycles believed to have curative effects (Devitt and McMasters 1998a; Gray 1980; Reid 1983).

*you what's wrong with you (Aboriginal Health Worker).*

*I think they do (respect doctors). I think people do listen to doctors a little bit more generally because they link their ongoing health with advice from us. I think we'll stand a better chance (than Aboriginal health workers) on the whole (Doctor).*

*That's been my impression previously, that people do respond to advice and I see no reason why that's going to change. People come along to the doctor to get advice; they are quite open to it, generally. Then if you give it to them in a non-judgemental, factual sort of way, and at the same time make it clear that you are concerned about their health, then I think people do listen. I don't think the doctor necessarily has got any greater ability to deliver the message (than an Aboriginal health worker). If the health worker is trusted and respected, I think the same sorts of things would apply (Doctor).*

A doctor who is known to the patients may have more power of persuasion according to these health workers:

*Aboriginal people get attached to people, with doctors and people and carers and whatever. They don't want other carer, if they get used to one carer, same with domiciliary care...*

*They listen to doctors, they trust doctors, more trust if they know them longer. People request to see a particular doctor*

There is also a sense in which Aboriginal patients *expect* doctors to give them advice. For example a middle aged diabetic man interviewed in Belyuen community near Darwin, said:

*It's every medical officer's job, you know, especially when you're overweight and you are a diabetic, that sort of thing they come up and tell you 'you're not supposed to be drinking' or, 'give up smoking, its no good for your pressure'. (L.S.)*

I suggested earlier that it is important for Aboriginal people to be able to refer to an outside authority in order to publicly legitimate and justify any change in drinking status. This is necessary because of what we know about the difficulties experienced by Aboriginal people in dealing with pressure from old drinking partners. A doctor constitutes an authority outside the individual. They are elevated in status and they reside metaphorically (and probably physically) beyond the social milieu of most Aboriginal patients. Unlike peers, family members, and Aboriginal Health Workers, a doctor fulfils the criteria necessary for an authorising external figure who can 'give permission' for an individual to engage in what would otherwise be socially unacceptable behaviour - turning down a drink. A medical practitioner is recognised by Aboriginal people as having an overarching moral and social right to express concern about a Patient's health. As such he or she becomes an authorising Other, to be utilised as a means of publicly announcing a change in drinking status. These two interviews provide an illustration:

*I told my mate 'I won't drink, I gibit away, very sick, nearly die'. They listen to me but they couldn't believe me, you know, too much drunk...Someone come up 'you never do that when you was young', they reckon, 'why don't you chuck me away?'<sup>35</sup> Why? 'Because you know why, doctor can't let me to drink'. After, now, they listen to me...(J.B.)*

*The doctor told me alright, 'you only got one life, you gotta just finish off because you still sick'. I went home to Kalano. And friend would come along, 'oh she's come back, we'll buy you dozen'. So my grandfather bought a six can for me. He put it in a plastic bag. And I said, 'no, I'm not taking that. I'm finished now. Doctor told me I only got one life. I finish, right out'. And they're laughing at me you know 'you liar, c'mon, c'mon'. 'Yeah', they said 'you used to drink before, what's wrong with you now? You changing!'. 'Yes' I said, 'because doctor told me I only got one life, because you can't say no to doctor when he's told you, you*

---

<sup>35</sup> This phrase 'why don't you chuck me away?' is an example of the use of emotional blackmail ; the speaker is implying that by not joining in drinking, his friend is rejecting him, throwing him away.

*want to believe doctor because he's a man doctor. When he tell you, he see you, everything inside your body. He tell you straight 'Give it up, don't you go back to grog'. Alright. And they said 'ok'. ...People coming back with grog, and I keep saying 'no, no, no'. Two years, they stop asking me then. (G.D.)*

#### 5.4. A critique of the role of doctors as providers of brief interventions

I have argued here<sup>36</sup> that there is persuasive evidence to support the contention that brief interventions to Aboriginal people will be more successful, more persuasive, and more acceptable, if they are delivered by doctors. However, it is important not to over-estimate this potential, for there are a number of drawbacks associated with the role of medical practitioners as advice-givers which also need to be addressed.

##### 5.4.1. Wariness of medical encounters

Aboriginal people have many more reasons than other Australians to be wary of encounters with the medical profession. Mobbs explains this as follows:

*Medical institutions and health-care agencies in Australia have been, and continue to be, powerful symbols of the colonial relationship between Aborigines and the dominant society. In the recent past, doctors held positions as government officials (such as 'Protectors') with enormous power over their Aboriginal wards. They also controlled access to health care for people who were often sick and in pain. As a result, many Aboriginal people have personally experienced feelings of intimidation and humiliation in a health-care (Mobbs 1991, p.315).*

---

<sup>36</sup> In material prepared for public health manuals and health practitioner-education, I have condensed the issues raised above into the following schema:

'There are five good reasons why health care professionals can talk about alcohol and other drug use with Aboriginal people.

They are *expected* to give advice, it's their job

Their advice is *personalised* rather than general, and linked to the person's health and situation

They are known to have *detailed knowledge* of the internal organs

They provide *external legitimisation* for the individual to change drinking habits. The person can use the health care provider's words as an excuse with other people

The interaction is *private*' (Brady 1995c).

In part, it was an awareness of these associations with colonialism, as well as rhetorical expressions of antipathy to 'bio-medicine', which influenced the Aboriginal health services in their early years of development to downplay the role and influence of medical practitioners. The vestiges of this conscious attempt to ensure that doctors did not have an inordinate amount of power and influence in community-controlled health services are still apparent in some services. For these reasons, an emphasis on the possibly superior role of doctors as deliverers of brief interventions, by-passing the role of the Aboriginal health worker, might be considered inappropriate by some of the more ideologically-driven health organisations. To some extent, encouraging doctors to be more proactive in their interventions over alcohol is to encourage 'medicalisation' of the issue (albeit in a different sense to the medicalising effect of the 'disease metaphor'). It can be argued that this further reinforces the power and status of doctors, and their ownership of applied science; it confirms their ascendancy over folk and lay practitioners (Marshall 1985). These arguments constitute an alternative view to some of the positive characteristics of medicalisation which were mentioned earlier.

Not all doctors are necessarily sensitive and suited to work with Aboriginal clients, or for the particular difficulties of delving into their alcohol use. Health professionals, like others, are socialised into a particular world view which is not always sympathetic to the experiences and meanings which Aboriginal people bring to their lives. It can take some time for doctors to put into practice the most appropriate non-threatening ways of dealing with their Aboriginal clients. These are usually thought to include the need for medical staff to establish a personal relationship with clients, and to put people at ease before embarking on the medical consultation (Hunter, Brady, and Hall 1999). Mobbs (1991, p.321) provides an example of a doctor who was able to do this:

*(One doctor) attempted to approach an Aboriginal patient 'as another person' and without 'a stethoscope hanging out'. After greeting the patient with 'Good day', he would ask where the patient had lived, whether they had relatives in hospital and*

*probably relate some of his own experiences of the area. He also felt it was important to use colloquial terminology during a conversation.*

On the other hand, in one Aboriginal community I was told of a local doctor who spoke to people 'rough way' about their drinking. It was said that drinkers responded by 'fighting' (ie resisting) him.<sup>37</sup> Weighing up these conflicting problems of sensitivity and forthrightness, a Northern Territory DMO commented:

*My initial approach vacillated between overwhelming cultural sensitivity and fear of mentioning alcohol, or, often because of frustration or horror at the advanced alcohol problems I was seeing in some Aboriginal people, an over-reaction to the other extreme, which was a moralising and patronising attitude to some clients. It took lots of years and the development of genuine caring and meaningful relationships with Aboriginal people before I seemed to make some advance in my attitude and therefore success regarding alcohol problems (K.E.)*

Positive and desirable attributes of doctors noted by urban Aborigines interviewed in Melbourne (Nathan 1980, p.112) included being 'approachable', 'concerned' and 'personalised'; good doctors 'thought Koorie' because they 'know and care for Koories'. In settings where the staff is Aboriginal, the clinic or health service environment is conducive to Aboriginal use, and where Aboriginal people feel at home, the barriers of class and brisk professionalism are less formidable. Speare and Kelly (1991) and Nathan (1980) make observations about Aboriginal views of what makes a health service convivial. Factors include a dislike of appointments and of long waiting times, the degree of rapport evident in a service (for example being greeted personally by a receptionist), personal contacts between doctors and patients outside the medical context, and the formality and physical appearance of the service (with people disliking expensive furniture and fittings). Familiarity between clients and doctors may have benefits and disadvantages. It is likely that a doctor working in an Aboriginal health service or with primarily Aboriginal patients will be familiar with alcohol related disorders and may be more familiar with the physical signs

---

<sup>37</sup> However, another interviewee cited this same doctor as having influenced him to quit drinking.

associated with heavy use. However, familiarity with the high consumption levels among many Aboriginal drinkers can lead to a degree of acceptance and tolerance which might not exist among other general practitioners. Medical staff dealing regularly with Aboriginal clients can become cynical, and be even less confident than those working in private practice that their advice could be influential. Clinicians may subtly communicate this so that expecting a poor prognosis can become a self-fulfilling prophecy of failure, as Donovan (1988) points out.

### 5. 5. Should Aboriginal health workers provide brief interventions?

Earlier I observed that Aboriginal drinkers show a strong resistance to interference, and to being ‘bossed’ by others who are their peers and co-residents, those who are perceived to have no moral right to pass comment on the personal conduct of an individual (even if it is patently damaging). This sensitivity exists among urban, as well as remote-dwelling people.<sup>38</sup> But how do these caveats reflect on Aboriginal people who are *employed* to intervene in peoples’ lives? Aboriginal health workers, a para-professional group whose role arguably includes offering health advice even on such sensitive issues as an individual’s weight, eating habits, smoking, drinking and sexual activities, can find themselves in intensely uncomfortable situations when dealing with their peers. These can be exacerbated by the closeness of an Aboriginal health worker to the community members involved, by the fact that they know individuals and families, and because they may interact socially with patients encountered in their professional work. While - ironically - these factors are the very ones which are said to be necessary for the creation of a culturally appropriate service,

---

<sup>38</sup> Among Western Desert people, another factor which militates against peer-intervention is a particular attribution made of drinkers: they are said to be unable to ‘hear’ expressions of concern or attempts at control. A number of linguistic devices are used to describe such people including *pina wiya* (which means ‘no ears’) or *pina una* (which means ‘useless/disused ears’). The ears are metaphorically the seat of understanding and comprehension, not simply hearing. People who have ears like this, are unable to hear or understand, to be like a child. These attributions are also made of young people who deliberately sniff petrol; they too are said to have ‘no ears’. In effect, it means that among this group of people at least, the social construction of drug taking is such that an individual is rendered incapable of listening to what others have to say, which makes it a waste of time for others to attempt dissuasion.

they may also serve to make life more difficult for the community health worker.<sup>39</sup> All health workers are said to be,

*...motivated by a desire to care for members of their family and the community and to improve the general health status and quality of life in their community. Within the range of their Aboriginal knowledge, medical training and constraints of the system, they deliver the best health care that they can. Everyone agrees that Health Workers are ideally placed to affect the health status of the community (Tregenza and Abbott 1995, p.15)*

However, health workers can encounter conflict between their medical responsibilities and other obligations, absenteeism and turnover are high in some regions, and they may be unwilling to take on the full range of responsibilities expected of them, especially in health centres attempting to Aboriginalise all aspects of health care (Folds 1985; Myers 1986, p.276-82). Tsey (1996) notes that they are increasingly expected to deal with complex and difficult problems, including alcohol-related health problems, but that the acquisition of professional skills is not keeping pace with these expectations. Added to these problems are those associated with social proximity. Professional 'distance' is made difficult by social knowledge<sup>40</sup>. Writing in the *Australian and New Zealand Journal of Public Health*, an Aboriginal health worker highlighted this dilemma:

*What we learn in the health worker sessions is often in clear contrast to how Aboriginal people, both urban and remote, govern their social lives. For example, as a professional health worker, our work involves giving advice to people about how things are affecting them and what might be contributing to their poor health.*

<sup>39</sup> The roles of Aboriginal health workers vary widely across the country, from the situation in some remote communities where a health worker may be responsible for a small clinic and be the only health professional immediately available, to metropolitan Aboriginal health services, where doctors and nurses are employed, and where the roles of the health worker may be more circumscribed. Their roles can include clinical practices such as immunisations, taking blood pressures, suturing, taking blood samples, pap smears, as well as those of cultural broker, health educator and promoter. Training methods and levels of qualification also vary across the country, with debate still taking place in some regions about whether or not health workers need to be literate, a matter which I discussed in Chapter Two (Tregenza and Abbott 1995).

<sup>40</sup> In an interview, one Aboriginal health worker said: 'When I walk in the door then I'm the same as them and they're the same as me. I've got a title, that's all and the title is used here'.

*As an Aboriginal person, it can be difficult to give advice in this way to other members of the Aboriginal community. It can sometimes be interpreted as interfering and telling people what to do or, even worse, as a personal criticism. If that happens, clients will respond quickly: they may get angry, walk away, or just ignore the health worker. Aboriginal people expect us to be courteous and respectful - that includes not telling them what to do (McMasters 1996, p.319, emphasis added).*

If health workers cannot be seen to be 'telling people what to do', then where does this leave their much-vaunted role in the vanguard of primary health care, as advice-givers and health promoters? Drinking behaviour is often considered to be the most sensitive issue for health workers to discuss, and when this subject-matter is combined with the constraints presented by social proximity, it becomes even more so. An example was provided by an anthropologist working in an Aboriginal health service. Sibthorpe documented the failure of a locally known drug and alcohol counsellor to survive in a job in which his demise,

*...was attributed by white staff at Durri to the fact that he was 'not local'...Aborigines whom I asked about his resignation stated however, that it was partly because he was local that people would not discuss their problems with him. They implied that this was the cause of a good deal of animosity towards him (Sibthorpe 1988, p.302).*

Interviews with Aboriginal health workers<sup>41</sup> provide insight into the difficulties they have in dealing with certain categories of patients. Several said that they would avoid asking particular people about their alcohol use on the grounds that it would be disrespectful:

*It's a lot easier now, because I've been doing it for over 12 months (screening patients for alcohol problems). It's a lot easier now. At first it was very hard. I felt invasive, very invasive (with) everybody. If they were relatives, I'd still ask, but (not)*

---

<sup>41</sup> Interviews with health workers at Nunkuwarrin Yunti, Adelaide, and Victorian Aboriginal Health Service, Melbourne.

*people who are older than me. Anyone who is older than me. Because I really couldn't bring myself to ask them. I honestly couldn't. I myself felt it would be insulting to even ask them (C.C.)*

*(I wouldn't ask people) older, over 60 people. Not in the age group anyway. I wouldn't ask a rellie (relative), they might slap me! (R.C.)*

Other health workers felt uncomfortable asking clients of any age questions about alcohol consumption:

*I felt uncomfortable in asking some of our clients these questions (the AUDIT screening tool). Being an Aboriginal person and asking another Aboriginal person it feels - I just felt uncomfortable. That's me, anyway; I don't know how the others felt. I'd make sure I approached the right person – I'd make sure it's someone that's not very aggressive or whatever - and see how they feel about it. I'd ask them first. If they don't want to do it, you can't force them to go through the process or anything (G.W.)*

A further cause of unease among health workers may be their own use of alcohol.<sup>42</sup> Because of the pervasiveness of an 'all or nothing' view of drinking among Aboriginal people, health workers - even those with moderate drinking patterns - feel hypocritical embarking on discussions about alcohol use with patients. Health workers in some cases drink in the same pubs as their patients<sup>43</sup>. The sense of discomfort and intrusiveness felt by Aboriginal health workers is not I suggest, only because of a disinclination to ask other Aborigines about their alcohol use *per se*. It is also because to ask someone about their alcohol consumption implies a lack of appreciation of the reasons why an individual might be drinking heavily.

---

<sup>42</sup> Indeed this is relevant for medical practitioners and nurses as well.

<sup>43</sup> This was pointed out by health workers interviewed in Melbourne. Indeed Aboriginal health workers may have drinking problems of their own (although dependence would make holding onto a position in a health service difficult). Smoking, for example, is extremely prevalent among Aboriginal health workers, which begs the question of their role in smoking interventions (Andrews, Oates, and Naden 1997). As they observe, health workers own use of tobacco and views about smoking will determine the extent to which they will be prepared and able to engage in tobacco control.

Aboriginal health workers explained that they were concerned lest patients *thought* that (by asking) they were insensitive to these underlying causes. They felt it was hard to ask about alcohol because it leads naturally to the reasons why people drink so much, and ‘that’s peoples’ private lives’. So it is also the social and familial *causes* of excess drinking which are deemed to be the no-go areas for questioning of Aborigines by Aborigines, not just alcohol use itself. As Aborigines, these health workers are expected to have an implicit understanding of and sympathy with the social, personal and economic factors that (are believed to) underlie alcohol abuse. Doctors on the other hand, are ‘outsiders’, who are not expected to have the same level of appreciation (as Aboriginal community members) of the factors in daily life which are believed to lead to alcohol abuse.

*They (doctors) won’t meet them on the street. They won’t weigh into them (Aboriginal Health Worker).*

*It’s probably better maybe, that it isn’t the Aboriginal health worker (giving the intervention). People will probably talk to the doctor. The doctor’s non-Aboriginal (Health Worker).*

To sum up, the available qualitative evidence suggests that at this stage in the development of the role of the Aboriginal Health Worker, there are many social and culturally-determined impediments to their being the providers of a fully realised brief intervention for alcohol use. They are generally unwilling to jeopardise their standing as members of the ‘community’ by engaging with others on this sensitive topic; they are not prepared to raise the issue at all with certain categories of people; and they do not wish to be thought of as delving into peoples’ private lives. They considered it appropriate for the doctor to be the one who provides such an intervention.

## **6. Impediments to implementing brief interventions for Aboriginal patients**

There are a number of barriers to the relevance and acceptability of brief interventions which are associated with socio-economic, educational and political factors. There are also

logistical problems of implementation which need to be addressed at the level of service-delivery.

### **6.1. Socio-economic and educational issues**

Perhaps the most obvious drawback to the use of brief interventions with Aboriginal drinkers is that of socio-economic circumstances, and the notable gap between their life experiences and those of the medical staff. O'Connor critiqued the type of advice and counselling that takes place during brief and other such interventions as being irrelevant in the Aboriginal context, and constitutes,

*...moral persuasion, using language and logic and appeal to Western values - losing your job, your comfortable home, your respectable family, your good name... Whether the jargon is rehabilitation, recuperation or counselling, when these white middle-class based enterprises are over, the client must again return to deprived and awful circumstances (O'Connor 1988, p.187, original emphasis).*

Awareness of issues such as those noted by O'Connor, prompted a Northern Territory doctor working in a community health centre to contribute these comments:

*The Aboriginal Health Workers and I would do an education program every year to alert the community to the dangers of alcohol. This consisted of a series of talks given by myself and the AHWs accompanied by films and pathology specimens of livers, brains and even a fetus that had been affected by alcohol. This would cause much light-hearted derision from the chronic drinkers in the community but made a big impact on the high school students from the Aboriginal unit at Nightcliff and Kormilda. The overwhelming problems of poverty, unemployment, disenfranchisement and overcrowding with poor living conditions, made any talk or counselling I gave at the clinic somehow hollow as it failed to address the underlying issues (K.E.)*

It is certainly important to bear in mind that the Aboriginal unemployment rate is approximately three times the national average, that average income is two-thirds of the national average, and that significant numbers of Aboriginal people live in what the rest of Australia would categorise as shanty towns of corrugated iron and tarpaulins. Imprisonment rates as documented by the Royal Commission into Aboriginal Deaths in Custody are extraordinarily high. More than twenty years ago, Chegwidden and Flaherty in their study of patients in a hospital detox unit in Sydney observed that only one out of 55 Aboriginal inpatients had *not* been arrested for drunkenness and that most had been arrested more than 10 times (Chegwidden and Flaherty 1977). Added to this is appalling health status of indigenous people with life expectation at birth being between 18 and 19 years shorter than for non-Aborigines (Kunitz 1994). Even such an apparently minor issue as deafness as a result of the prevalence of *otitis media* infections is relevant here. Certainly there is a degree of middle class logic which can pervade some intervention and counselling styles (for example arguments that drinking might mean losing your job, or your house assume that you have a job or house to lose). However, it needs to be said that AA has *also* been critiqued by indigenous people as having a middle class orientation (pointing the way back to a middle class way of life and a work ethic). According to two American Indian psychologists, participating in AA-style groups 'may reinforce feelings of failure and domination, which are theorised by some psychological researchers to be causes of substance abuse' (Duran and Duran 1995, p.102).<sup>44</sup> Taking on board some of these criticisms, it is nevertheless true to say that giving brief advice and opportunistic intervention by doctors should never be interpreted as being an *alternative* to more intensive, long-term procedures which are necessary for many chronic and deteriorated drinkers. It is clear that the relevance and impact of honest assessment and discussion is undoubtedly dependent on numerous factors including the existence of some social supports, and a readiness to change. Obviously, these are not present in a number of cases.

Another hurdle to the efficacy of brief interventions could be poor levels of education, which are known to influence the degree to which individuals are open to new ideas, and to

---

<sup>44</sup> Room (1985a) points out that the addiction concept and 'controlled drinking' both have an emphasis on self control, which is an especially middle-class way of defining and looking at behaviour.

influence levels of understanding of medical problems. We know, for example, that even among urban Aboriginal populations, there can be poor school completion: users of the Tharawal Aboriginal Medical Service in Cambelltown, Sydney found that 40 percent of adults had not completed education *beyond primary school* (Tharawal Aboriginal Corporation 1994). This means that the use of reading material and self-monitoring tools such as diaries - which are often provided to the general population in conjunction with brief interventions - would not always be appropriate. However, most Aboriginal health services produce their own pamphlets and bootees on alcohol use written in the vernacular (or Kriol), often with locally-drawn illustrations, which helps to ameliorate this problem. It must be said that low levels of education and literacy, and in some regions the use of English as a second language, also raises the issue of the extent of client comprehension of what takes place in some residential alcohol programs. There are often heavy doses of 'alcohol education' and convoluted theorising taking place in these longer-term facilities.<sup>45</sup> Comprehension problems are known to exist in these situations (Miller and Rowse 1995; O'Connor 1988). Brief interventions have an advantage in that they need not engage in verbiage and abstract theorising.<sup>46</sup>

## 6.2. Attitudinal, ideological and theoretical issues

There are a number of attitudinal and ideological factors which need to be considered if brief interventions are to be implemented with indigenous clients. For example, there is some evidence that existing Aboriginal service providers *perceive* interventions such as these to be inappropriate because Aborigines drink so much. This grassroots knowledge of the truly enormous amounts consumed by some drinkers together with the prevalence of a unitary view of the 'alcoholic' and misunderstandings of 'harm reduction', have produced a disempowering and hopeless attitude among some service providers: 'Once you're an alcoholic you're an alcoholic to the day you die' (Schaler 1996). Aboriginal agencies

---

<sup>45</sup> Some of the material reproduced by Canadian Indian consultants for Aboriginal program use in Australia is particularly dense in this regard.

<sup>46</sup> Allsop (1990) observes that some clients in treatment have an impaired capacity to process and recall information, as a result of alcohol-related brain damage.

responding to a national study of treatment approaches (Brady, Dawe, and Richmond 1998) provided views such as these:

- *'(Brief interventions) would be useless; our clients are all at the end of the line';*
- *'May be (helpful) but not up here because problem is so big. Couldn't teach controlled drinking to Aboriginal people, Aborigines are different types of people (they) drink metho, brake fluid, although that is the same for white people';*
- *'Drug and alcohol abuse has taken years to develop and takes a long time to break down. Brief interventions are not intensive enough'.*

These objections undoubtedly have some validity. According to research findings on the implementation of techniques of simple advice and brief intervention by generalist health professionals, they are indeed not thought to be persuasive for dependent 'alcoholics'. Also, many Aboriginal service providers appear to associate brief interventions with goals of moderation rather than abstinence, and position themselves accordingly. Because brief intervention style techniques *appear* to be associated with harm reduction rather than with abstinence goals, they seem to threaten proponents of the disease model and those who believe that abstinence is the only acceptable goal for Aboriginal drinkers. I have discussed the dominance of this thinking, and its association with the argument that Aboriginal ex-drinkers are the 'best' people to engage with drinkers. Because all Aboriginal treatment programs employ ex-drinkers, these individuals also draw on interpretations of a personal experience:

*Controlled drinking will never work, that first drink will take them back to where they were before. (I) tried to drink sensible but doesn't work. Once you're an alcoholic you're an alcoholic to the day you die. I wouldn't stop at 1,000 once I'd had one.*

Of course brief interventions are not necessarily associated either with abstention *or* with 'controlled' drinking - they are simply based on the notion that a health professional, particularly a doctor, has an important part to play in motivating an individual to consider

his or her drinking and the impact it is having on their physical or social well-being before this impact (and consumption) becomes unmanageable. If a patient who is obviously suffering serious harm as a result of drinking presents to a doctor, then the practitioner is obliged to recommend abstention. In other cases, the formula for brief interventions recommends leaving the decision to abstain or cut down up to the patient. Just as harm minimisation approaches such as these do not imply approval of drinking, neither do they imply that the eventual goal of intervention cannot be abstention. It can be a first step in the process of a decision to abstain (Plant, Single, and Stockwell 1997, p.6). Apart from these philosophical objections which may arise, there may also be ideological objections to valorising the role of the doctor. The suggestion that doctors - who are both professionals and non-Aborigines - have an important pro-active role, may meet with resistance if this role is interpreted to disenfranchise Aboriginal para-professional workers. Aboriginal para-professionals are often employed on the grounds that they are ex-drinkers, and therefore 'know best'. To admit that the role of intervener could be allocated to a non-Aboriginal person, who is not an ex-drinker, would be to undercut the very reason for hiring Aboriginal ex-drinkers in the first place. In addition, as Levy and Kunitz point out in a discussion of the resistance of US Indian drinking programs to innovation, the position of the para-professional is often tenuous and they may feel insecure. Their jobs are dependent on ongoing funding (usually from the Federal government), and they lack long years of professional education (Levy and Kunitz 1981). To admit the need for research or for innovative ideas in treatment despite being Aboriginal and an ex-drinker would be both to admit ignorance, and to acknowledge that one did not have all the answers.

A further attitudinal barrier to the endorsement of strategies such as brief interventions by non-specialist health professionals is that these could be perceived by Aborigines to be 'mainstream' programs not designed specifically for indigenous people. Brief interventions is indubitably a treatment technique emanating from the mainstream clinical and research community, and has only been disseminated relatively recently (in Australia) among a limited number of general practitioners. For the reasons discussed earlier, it may be thought to have a 'middle class', or indeed a 'white Australian' orientation. It is certainly important to evaluate critically the applicability of new

treatment approaches and ‘fashions’ as Robin Room (1985a, p.138) has cautioned, for professional enthusiasm can occasionally lead to the application of models in circumstances which are inappropriate. There is, however, a perceptible change of orientation taking place among *some* Aboriginal service providers and organisations<sup>47</sup>, which suggests a new openness to these ideas and an examination of their applicability, rather than rejecting them outright. At least one Aboriginal-controlled residential centre (Milliya Rumurra in Broome, Western Australia) runs both an abstinence-oriented AA program *and* a social learning ‘controlled drinking’ program within the service and has found both programs can run concurrently without conflict (Ikin 1999).

There is one further debate that should be mentioned in this discussion of impediments to implementing widespread brief interventions for indigenous clients. It concerns the theoretical underpinnings of the population-based approach which encourages *everyone* to lower their consumption. In practice, these are associated with occasions in which a health professional might screen *all* patients (whether or not they show overt alcohol-related problems), and advise people to decrease the amount they drink.

The population-based approach was based on the ‘prevention paradox’,<sup>48</sup> as it applies to alcohol, elucidated by Kreitman (1986; Rose 1994) who proposed that it was the individuals who consumed usually at *low-risk* levels who incurred the most harm, simply because they were more numerous than heavy drinkers. This paradox is based on a model of alcohol consumption which assumes that in the population there are a few abstainers at one end of the spectrum, and a few alcohol dependent people at the other, with the bulk being moderate alcohol consumers. If you could persuade this large group to cut down on their drinking, then alcohol related harms would be reduced (Roche and Evans 1998; Rose 1994). This paradox provided the impetus for strategies in Australia which were

<sup>47</sup> For example the fact that Congress health service in Alice Springs is encouraging its doctors to engage in brief opportunistic interventions, and that a number of other Aboriginal units in state health departments are implementing them. There are now more tertiary courses attracting indigenous students which cover theories of addiction, and which recommend readings such as Prochaska and Di Clemente’s work on stages of change (eg Flinders University in South Australia). Together with the slow demise of the original cadres of Aboriginal alcohol workers and their gradual replacement with younger, better educated workers, these developments suggest that broader approaches are beginning to gain ground.

aimed at lowering aggregate consumption. Not only is this a difficult and counter-intuitive proposition,<sup>49</sup> Aboriginal drinking patterns do not fit the paradigm. Their patterns of alcohol use show that there is a substantial proportion of abstainers, very few using alcohol in a low-risk manner, and the majority of users drinking hazardously or harmfully. Among Aboriginal people, then, it is the heavy drinkers who are more numerous. Persuading the few moderate users to drink less will arguably have little impact on the overall harms associated with Aboriginal alcohol abuse. In some cases, population-based reduction-of-consumption campaigns based on educating people about standard drinks (for example the Living with Alcohol program in the Northern Territory) have failed to take note that Aboriginal drinking patterns do not match the principle behind the prevention paradox.

Some researchers are now urging a more targeted high-risk approach which attempts to specifically reduce harmful and hazardous drinking: ‘avoid problems when you drink’ (Plant, Single, and Stockwell 1997; Roche 1996b; Stockwell et al. 1997). This message is said to be complementary rather than contradictory to the message that drinking less is better, to be practical rather than idealistic, and to be oriented to decreasing adverse consequences (Plant, Single, and Stockwell 1997, p.7). Stockwell and colleagues argue that this more targeted approach would have macro-level strategic advantages:

*A policy which stresses the need to reduce harmful and hazardous drinking (rather than one which tries to get everyone to drink less) is harder to oppose and, in fact, is frequently espoused by alcohol industry advocates. We submit that such an approach is more likely to win support from politicians and draw less effective resistance from the alcohol industry than approaches which stress the need to reduce total consumption (Stockwell et al. 1997, p.5)*

<sup>48</sup> Rose (1994, p.12) describes the classic prevention paradox as being an *irony*: a preventive measure that brings large benefits to the community but which offers little to each participating individual.

<sup>49</sup> In fact Roche and Evans (1998) argue that alcohol itself is an exception to the classic public health arguments that, for example, everyone should cut down on salt and fat in the diet even though only a few are susceptible to hypertension.

While this strategic argument has some merit, it could be argued that it does appease industry representatives, who prefer models focussing on a few problematic or alcoholic individuals<sup>50</sup> and who strenuously oppose many public health alcohol strategies.<sup>51</sup> I believe that it also has micro-level advantages in the Aboriginal context, and in the context of the focus of a brief intervention. Like other Australians - who seem to be prepared to support sensible strategies which deter behaviours which make harm likely - there is more chance that Aboriginal people will support approaches *which are seen to target high-risk drinking, rather than merely urging moderation.* If brief interventions were to be explained to Aboriginal service providers in this way, and disseminated as attempts to target problem drinking occasions, circumstances and environments, then some of the philosophical and ideological objections to them (tainted with misunderstandings of 'controlled drinking') could melt away.

### 6.3. The prevalence of social problems as a barrier

The effectiveness and relevance of brief interventions undertaken by doctors or other health professionals is based upon the assumption that an individual will be swayed by the association of their drinking with *health* problems. While this assumption is borne out by considerable anecdotal evidence and by the majority of recovery narratives, people also cite other, social, factors as having influenced them to reconsider their drinking behaviour. Of the 45 self-quitters, eighteen nominated a primary reason other than an alcohol-related health reason for changing their behaviour. The influential factors for these individuals included losing a job, losing a driving licence, family responsibilities such as having 'too many' children or elderly parents to look after, too much fighting or

---

<sup>50</sup> It may, unfortunately, reinforce exaggerated perceptions that 'controlled drinking' is a plot by the alcohol industry to maintain its profits

<sup>51</sup> For example, the Distilled Spirits Industry Council of Australia is opposed to proposals (said by them to be advocated by 'vested interests') to include mandatory health warning labels on alcohol beverages (Newsletter 4(1) June 1999); the International Centre for Alcohol Policies (an industry-funded organisation in the US) circulated a report on 'What is a standard drink?' which drew attention to a 'lack of consensus' on such definitions, whilst disseminating information on the health benefits of alcohol use. Hutt (1998) presents a detailed analysis of an alcohol policy debate in New Zealand in which the relative merits of the population based reduction of consumption approach versus targeted high-risk strategies were at issue. The alcohol industry in New Zealand vehemently opposed the view that overall consumption should be reduced.

arguing, spouses leaving, work responsibilities, miraculous or mystical experiences, and traumatic vehicle accidents including being responsible for the deaths of others. Nearly all interviewees nominated a mixture of health and social reasons. Some were simply ‘sick’ of everything brought on by their drinking behaviour. There is no doubt that at a community or neighbourhood level, as well as for many individuals, concern over drinking *behaviour* and the social ramifications of it are of crucial importance, perhaps of more importance than concern over the health of the drinkers. For example, the ‘bad things about drinking’ nominated at a community workshop in a remote Western Australian community were as follows:

*Fighting. Stealing. Accidents. Family break-ups. No money. Hangover. Court. Prison. Hospital. Suicide. Losing Law. Making enemies. Jealous. Losing respect. Losing licence. Getting sack. Losing culture. Wrong-way love. Stress. Blackout.*

The ‘good things about not drinking’ were said by participants to be:

*Look after family. Think clearly. Get job and money. No fighting. Happy kids. Nice clothes. Rent paid. Family together. Aware of others. No sickness. Get support. Happy. Money for travel. Good environment. Get respect. No one in lock-up. Self control.<sup>52</sup>*

Health issues are mentioned in these lists, but they are far outweighed by factors associated with sociality, relatedness and social well-being. Relatedness and demonstrations of it are major components of daily life (far more so than ‘spirituality’), and while alcohol is used by drinkers ostensibly to communicate their relatedness (through sharing, exchange and conviviality), intoxication is often counter-productive to relatedness.<sup>53</sup> This is because when people are intoxicated they may abuse relatives both

---

<sup>52</sup> The workshop was jointly convened by the WA Alcohol and Drug Authority and the Ngangganawili Medical Service (Wiluna); (Brady 1998, p.74)

<sup>53</sup> A corollary of this is that drinking *allows people to escape* from the crushing and persistent expectations of others, the pressure of so many relations, the numerous rules and obligations that need to be fulfilled. Aboriginal people sometimes absent themselves from this situation by going on prolonged binges in which they disappear from their normal social network. David McKnight has written about the stress of what he

physically and metaphorically: there is violence, verbal abuse, hounding and stealing from kin. There are rejections, personal slights and unsanctioned liaisons. Several ethnographers have documented in detail the complex expectations that surround concepts of relatedness, caring and compassion which are compromised by intoxication (Brady 1992b; Martin 1993; Myers 1986). Writing on the emotion of anger and its expression among Western Desert Pintupi people, Myers explains that drunkenness is a common occasion for violence and indeed it is utilised in order to demonstrate anger: 'I might get you any time, when I'm drunk'. Drunkenness is, he says, a culturally acceptable excuse for being out of control and for not recognising relatedness to others (Myers 1988, p.599). This is because under the influence of alcohol one is not oneself, and therefore not responsible. Drunks therefore breach the normal expectations of compassionate behaviour: they fail to fulfil their responsibilities to family members. In fact, it is this outcome of drinking to which Aboriginal people are alluding when they announce that drinking makes people 'forget' their culture: they are not necessarily referring to the loss of 'high' culture (such as ceremonial performance, or knowledge of land and songs associated with land-holding), but to socially unacceptable breaches of interpersonal etiquette such as the denial of relatives by not caring for them. Several of the ex-drinkers who provided personal narratives of their experiences expressed remorse over their breaches of expectable social behaviour:

*Too much trouble you know, arguments, fights no good. ...we used to drink together and we used to start fighting. 'You bin fighting last night, you'll just have to go, go somewhere else' - It bin hurt my feeling, I didn't want to do to my friend like that. Oh, I had a lot of fight with friends, but after a while, I bin thinking a lot you know. ...used to go mad with my wife not cook for me, just from cooking tucker and all that (R.B.)*

---

terms 'relational density' which is notable in some Aboriginal communities due to increased population size. This is the density of others known to an individual by kinship terms, all of whom demand obligations and commitments, duties and responsibilities, placing a heavy strain on relationships and the social system as a whole (McKnight 1986, p.152-153).

*You even fight your friend, and you says all the silly word. And when you come sober some of them sober people tell you 'hey you bin doing that' and you hardly believe what you bin saying. (D.B.)*

Looking after the family, caring for children and wanting to see grandchildren grow up are important motivations for change among some Aboriginal drinkers. For example, a Pitjantjatjara woman said of her husband who had stopped drinking that he 'worried that he might not see grandchild grow up. First one, gotta feel sorry (ie show compassion) for granddaughter. Think hard. *Anangu* way they bin worrying [thinking in an Aboriginal way about not participating in the upbringing of a grandchild]. "I might pass away. I might give up and grow em up" '. Several ex-drinkers had been left by a spouse; another found his wife and children 'backing away' from him. One man was wracked by guilt at having caused the deaths in a car accident of some other young men; he felt as if he had 'done the murder'. 'That made me more shook up. Because of grog you can do a lot of things. You can see when you're sober, more peaceful and more comfortable, you can do more things better'.

In these cases, the poor health of the drinker was less of a priority, and less distressing, than the social havoc brought about by the person's alcohol abuse<sup>54</sup>. Several interviewees recounted chronic and traumatic health problems in their drinking career, but in the end it was a social or familial reason which they attributed as being the decisive one, not the health problem. At issue here is the fact that medical staff - for the most part - are only able to utilise personalised health problems as the tool of persuasion; they are not usually in a position to know of these additional factors which might motivate people to think about their drinking, and might not consider it to be within their brief to bring these issues up. Nevertheless, if an individual is drinking heavily on an irregular basis (ie bingeing), this style of drinking is more likely to be immediately associated with accidents and violence (rather than with general alcohol-related health problems) in

---

<sup>54</sup> On the other hand, an individual may be consuming enough alcohol to cause physical harm to himself, but be a 'quiet' drinker. Because he is 'quiet' (ie does not get involved in violence, or arrests) he, and others around him, may not categorise him as a problem drinker at all, or perceive that he is at risk.

which case a doctor has good cause to point out this high-risk association. This may lead a patient to disclose negative social effects of their drinking. A brief motivational interview is designed to allow the *client* to define the problems and nominate the things that concern him or her about their drinking. An Aboriginal patient's problem-definition may be quite different to that of the doctor.

#### **6.4. Logistical impediments to implementation**

Other issues to be taken into consideration when considering the appropriateness and feasibility of brief interventions in primary health care are of a logistical nature. They include the problem of time-management during consultations, appropriate training for staff, and Aboriginal sensitivity to screening and survey instruments.

##### **6.4.1. Time**

Time is always an issue in any health service, and because Aboriginal clients usually present with more than one health problem, doctors may be more stretched for time than in other situations. Doctors are now more than ever under pressure to screen patients and engage in prevention for a variety of ailments, and this is particularly so in services catering to Aboriginal needs - this is yet another disincentive for those who feel they have quite enough to do without adding alcohol interventions to the list.

Doctors who work on salary for Aboriginal health services seem to spend longer with their patients than do doctors in private general practice, with staff in two metropolitan services estimating that their consultations last between twenty and forty minutes. Spending enough time with a patient is said to be an important feature of Aboriginal perceptions of what constitutes a good service (Aboriginal Health Organisation of South Australia 1989). Independent Aboriginal health services have differing regimes for the operation of their clinics, some dealing with people in the order in which they arrive, others using appointments. Some have a system of same-day appointments, or a mixture of the two. Without appointments, waiting rooms can become congested with longer waiting times before clients can see a doctor, and this can contribute to medical staff feeling pressured and

as a consequence make it more difficult for them to raise alcohol for discussion if it is not obviously indicated by the presenting problem. Some health services have limited clinic opening hours. Staff at Nunkuwarrin Yunti made these comments on the limitations of time and poor health:

*The centre is pushed for time in some ways (Doctor)*

*Pressure for time. Some patients have a long chronic history (of drinking) (Doctor)*

*You can't spend all the time on alcohol when they have complex problems. A lot of the patients have complex, complicated and other medical problems and you can't devote the whole of the interview to talking about their alcohol problem if they've got diabetes, hypertension, heart disease and some other problem (Doctor)*

*There are so many things to be done with each client. (Doctor)*

*One person felt they'd come in for what they saw as a health reason and felt more time was spent on this (alcohol) ...they were a bit annoyed (Doctor)*

#### **6.4.2. Training**

Training is an important mechanism whereby any health professional can gain more confidence to approach a client's drinking during a consultation. Training in brief interventions and motivational interviewing is provided to general practitioners and other health professionals through a number of research and training organisations, and often brief intervention techniques are disseminated as peer education, by specially trained doctors. The existing formulae for brief interventions offered in these training sessions however, do not take into consideration some of the special factors that may be relevant for their use with indigenous clients. For example, some intervention schema encourage clients to keep a diary of their drinking, they may be given a booklet, advised to set a date for making changes, and encouraged to develop a plan of action. All these can be difficult for people with low literacy levels or unmanageable home situations. Doctors usually provide some 'tips' to help

patients cut down on their intake, and these strategies need to be adjusted so that the ideas are recognisable and useable by Aboriginal clients (for example a relevant tip would be not to take much money to the pub). It is not easy to pitch training at just the right level for health professionals; one of the problems may be that medical practitioners working in Aboriginal health services are already sensitised to the gentle probing encouraged by motivational interviewing techniques, and find some training modules patronising. On the other hand, training usually serves to bring the alcohol issue to attention when it might otherwise be set aside, especially if it is followed up by providing doctors with some teaching tools such as flip charts or pamphlets to use in their consultations. Views of training from Aboriginal health service doctors in Adelaide included the following:

*It did improve my practice - because you're more aware of it, and its more at the front of your mind than at the back of your mind (S.N.)*

*I am more confident to talk about it, its much easier to talk about it (D.C.)*

*(The training) helped to broach it. In (a mainstream health service) with the young people, I have started using it with their other drugs. They also use other drugs, intravenous speed and heroin and other things. That has helped me in application about those too. It has helped me apply it in other areas too - smoking for example. (A flip chart) was good for the client to focus on something and then initiate the discussion. I found it really useful...It makes them think, 'Oh, is that really high? Am I drinking too much? Am I above this level?' It made them think and there was evidence, so it was good. (V.R.)*

*I really like the flip chart. It's a prompt for me. In fact, when I put this in front of the patient, somehow it gives me a connection to him, and then we can talk, there is a focus to talk about...being visual. And there's no finger-pointing or something like that. You just say 'this is the one. And this is where you are'. So there is an indirect way of saying it (D.C.)*

*It hasn't helped to broach the subject in situations where it's not appropriate. But the technique (good and not so good things) has helped me to counsel people (N.C.)*

#### **6.4.3. Assessment**

The logistics of introducing brief interventions into a practice include screening and assessment.

Although Aboriginal patients, like any patient, expect to be asked questions by doctors, being questioned is still a sensitive matter for many Aboriginal people, and doctors need to be aware of these sensitivities.<sup>55</sup> Nevertheless screening or a brief assessment of a patients' alcohol intake is essential if doctors are to engage in any discussion on the topic.<sup>56</sup> Discussions about alcohol use are less likely to be threatening to patients if they are part of an overall health or lifestyle screening. New patients will have a medical history taken (which would usually include an assessment of alcohol consumption) which provides an up-to-date indication of harmful or hazardous consumption. If clients are already known to doctors, and are long-term patients of a particular service, this might make it more difficult for some doctors to broach alcohol use as a new topic. On the other hand, familiarity between the doctor and Aboriginal client was nominated by one doctor as enabling him to pursue the issue:

*Some people say 'right, that's enough' and don't want to hear any more. There are times when if someone backs off you could still be in a position where you would press a bit further. Because you've seen them for a long time, there's a level of trust that you have established, you are in a position where you can talk to them perhaps a bit more firmly and be a bit more persistent than you otherwise would. It's really a matter of judgment and you need to individualise your level or advice and intervention (Doctor))*

---

<sup>55</sup> It is also possible that some doctors working for Aboriginal-controlled services may be less willing to raise alcohol issues with patients because of the known political sensitivities associated with the stereotyping of Aboriginal alcohol abuse; a sense that it is 'politically incorrect'.

<sup>56</sup> Conversely, there should be no screening without adequate resources for advice - in the absence of any follow-up it is likely to be ineffective (Rose 1994, p.35).

An alcohol screening, which does not necessarily have to be a full questionnaire such as the AUDIT, but can rely on two or three questions on consumption and risky drinking, is very useful to medical staff:

*Once something has been identified then it's much easier to tackle it. If its been asked as part of a routine screening question, then its much less threatening than if it's asked in the context of something else (S.N.)*

*Techniques help to break the ice - there is the screening and I base it on these 'you are drinking this much', if there's the screening. (D.C.)*

It would be helpful for doctors to know something of Aboriginal drinking styles in the area in which they work which can better inform the taking of a drinking history. For example during screening, a patient might state that he consumed several bottles or flagons of fortified wine in conjunction with several other people over a matter of hours. The doctor could assume that the person was a regular binger. However a patient may live in a community which has been declared 'dry' and therefore be on a relatively rare binge. He or she may be responding to a particular acute event - such as bereavement - by drinking heavily for a restricted period of time. A patient may report truthfully that he has not had a drink in the month before the consultation, which does not necessarily indicate improved drinking behaviour, remission, or the absence of a drinking problem. A culturally-aware doctor would therefore be more concerned with the frequency of the drinking episodes and the length of time during which they had been occurring (Topper 1981). It may also be 'normal' (from the Aboriginal point of view) to consume amounts considered extraordinary to outsiders, and in this case a patient would need additional discussion to help to place this apparently normal consumption in the context of what are medical definitions of harmful consumption. It can help if the patient is shown where his consumption fits in along a continuum of harm, or by comparison with the general population<sup>57</sup>. A service provider working with Aboriginal people needs to be aware of and concerned with the frequency of

---

<sup>57</sup> This usually means comparisons with the consumption patterns of Australia as a whole, not indigenous people as a whole.

drinking episodes, and how long this pattern has persisted, as well as with the actual amounts consumed on any one occasion. Not all assessment tools take these into consideration. Another problem is the administration of longer screening tools, such as the AUDIT<sup>58</sup> as there is some evidence that Aboriginal clients find them excessively confrontational, and may misinterpret the questions:

*The AUDIT is far too long...off-putting to patients. There is a degree of intrusiveness there, because maybe people are more sensitive about alcohol (Health Worker)*

*Not comfortable (with AUDIT). They come for other reasons (Doctor)*

*They were accepting it well, but sometimes it would need clarification as to 'After, do you feel guilty?' They (the patients) said 'feel guilty?' - you know. (So the doctor had to explain the question by saying that it meant: 'do you feel "I wish I hadn't done that?"') (Doctor)*

There is only anecdotal and conflicting information from elsewhere about whether or not tests such as the AUDIT constitute more of a barrier than an opening to further probing about alcohol use.

## **7. The question of difference**

In this discussion I have raised a number of factors which seem to be peculiar to Aboriginal ways of life and understandings of the world, and which have a bearing on whether or not brief interventions as one form of secondary prevention would be feasible, appropriate and acceptable to them. For example, I suggested that Aboriginal people have a special need for an external authorising 'other' who has the authority to provide them with advice about changing drinking behaviour, partly because of the unhelpfulness of family and friends in

---

<sup>58</sup> Another screening instrument used with indigenous populations in Australia is the CAGE (Hunter, Hall, and Spargo 1991).

this endeavour. Only an individual with these characteristics can be used as an excuse for the benefit of Aboriginal drinking consociates. I suggested that Aboriginal people are subjected to a particular form of unremitting pressure from family and 'mates' to drink and to remain drinking; that they bear the brunt of emotional blackmail and rejection if they give up drinking. I also provided evidence that Aboriginal notions of personal autonomy can mean that they are unusually resistant to any advice or interventions around drinking behaviour which emanate from their peers. Qualitative accounts of motivations to change drinking behaviour among indigenous people who recovered from alcohol problems without formal treatment were also discussed. In analysing the logistical and other impediments that exist in the implementation of brief interventions for Aboriginal people in a primary health care service, I cited Aboriginal perceptions of what constitutes a caring and convivial health service and what expectations they have of doctors and health workers. All these may potentially influence the processes of secondary prevention for this segment of the general population.

However, I am also acutely aware of the fact that many of these factors are highly relevant to patients coming from the majority Australian population, not just to Aboriginal people. Many individuals are resistant to advice or questioning on their use of alcohol, indeed researchers have given this a name: 'psychologic reactance' (Rollnick, Heather, and Bell 1992). For this reason, *all* patients need to have good reasons based on authoritative advice from a trusted practitioner in order to contemplate changing their alcohol or drug consumption. The need to stress autonomy and self-efficacy of decision-making in behaviour change are referred to in the mainstream literature (Bien, Miller, and Tonigan 1993). We know that in the general population there is also strong social pressure to consume alcohol and other drugs, to over-consume at times, and that attempts to extricate oneself from these consuming peer-groups can be met with derision, especially among the young. In other words, the setting in which use occurs is highly influential for everyone (Pearson 1987; Zinberg 1984). The extended family and friends can be counter-productive to those attempting to give up drinking in several societies (Orford 1992). We also know that drinking together is a symbolic means of affirming social relationships, not just among indigenous people, but among others in the wider society (Adler 1991; Brady 1988). In the

slowly increasing literature on spontaneous remission or 'natural recovery' among samples of non-indigenous people, many of the motivations to change nominated by, or deduced from, interviewees were similar to those nominated by the Aboriginal and Torres Strait Islanders I interviewed. These included the accumulation of distressing events, concern about family and social relationships, health problems, getting fed up with the lifestyle; increased responsibilities, and even a single warning from a doctor (Burman 1997; Klingemann 1991; Sibthorpe and Lear 1994; Stall 1983).

In terms of the role of primary care interventions, patients in the general population attending general practice have expectations of their health services, wanting their doctors to be approachable and concerned, to be good communicators and spend enough time with them (Lewis 1994; Williams et al. 1995). They expect staff to be friendly, to greet them personally, and they dislike having to wait (Billinghurst and Whitfield 1993; Lewis 1994; Williams et al. 1995). All patients in primary health care need to be put at ease in medical encounters, and have a right to be treated with respect. Just as with Aboriginal people, members of the general population sometimes attribute greater importance to diffuse and intangible aspects of primary health care such as the nature of the doctor-patient relationship, rather than more obvious and tangible aspects (Williams and Calnan 1991). Like Aboriginal people, members of the general population generally have faith in doctors (Lewis 1994; Williams and Calnan 1991).

In the context of the feasibility of secondary prevention for indigenous alcohol use, many of the issues I have raised which are said to be specific to indigenous people, or which are apparently necessary in order to be 'culturally appropriate' for them, appear in many cases not to be so very different or specific after all. On the other hand, I have articulated several important reasons why brief interventions potentially provide a good accommodation of the very real social and cultural differences which mark out Aboriginal lifeways and understandings of their world. This raises a key question. Should brief interventions (as one example of a secondary prevention activity) be disseminated to Aboriginal clients because they do dovetail with these specific (and different) elements in Aboriginal social life - because they are 'culturally appropriate'? Or should they be made available to indigenous

people because we know them to be reasonably effective in the general population, and the supposed differences between indigenous and non- indigenous people are actually fewer than we think?

I propose that both these propositions are true. There are many features of the life experiences of Aboriginal people that make their relationship with alcohol different. Features of daily life for many Aboriginal people serve to induce a particular sociality and intensity around the drinking act, which contribute to the immense difficulties they experience in extricating themselves from it. Not the least of these is the existence of chronic ill-health, unemployment, poverty, the daily struggle for survival, and the concomitant narrowing of options associated with these factors. There is undoubtedly a greater emphasis among Aboriginal people on mutual interdependence, on demand sharing, and in affirming relatedness - all of which are embedded in the long-standing exigencies of culture, but which are accentuated by low socio-economic status. For these reasons, the need for external sources of motivation to change, proof of the need for change, and non-judgemental assessment of harm are all highly indicated. These are the reasons why brief interventions could be of particular use to Aboriginal people. As well as this, it is of the utmost importance to accept that these interventions should be provided to indigenous people because they are part of the overall population, and because they have many similarities with all those who experience harm from alcohol misuse. These interventions are also called for because the provision of secondary prevention activities to date has been grossly neglected in favour of primary prevention and education campaigns on the one hand, and tertiary residential treatment on the other.

## **Conclusion**

Any health intervention, to be successful, must garner the willing and active participation of the client - and herein lies the nub of the problem of prevention and treatment. In the case of Aboriginal people, all the evidence suggests that Aboriginal people have many more reasons than other Australians to be wary of health professionals and contacts with health services. Low socio-economic and educational levels, constraints of time, transport and access, as

well as having priorities other than health are also barriers to participation in health improvement. It is for these reasons that what is known as community control of service provision is necessary, although it is not sufficient, to guarantee success in these approaches. Ideally the context and ambience of the service, the rapport with professional staff and the sense of belonging to and familiarity with a service should all combine to facilitate a willingness to join in with the process. As Ian Anderson observes, it would be wrong to assume that self determination is a principle only appropriate to overt political activity:

*The implication of any health intervention is that the recipient will consent to change aspects of his or her behaviour, and possibly values. This is an ethically difficult position for service providers, particularly given the history of coerced social change and Aboriginal communities. However, not only is it ethically wrong to impose change on people, it is actually impossible in any comprehensive sense, unless you want to regulate every aspect of their lives. This is one reason why self determination is a necessary principle of Aboriginal programmes. It is only realised where programmes are structured in such a way as to allow Aboriginal people to engage with the possibilities, have the necessary resources to make changes, and be convinced that the changes will enhance their lives (Anderson 1994b, p.35-36)*

If developments such as brief interventions are found to be appropriate, and if they are to become an accepted part of the range of early interventions available to Aboriginal as they are to non-Aboriginal people, then the factors that Anderson mentions should ideally be present. Notwithstanding the potential role of community-controlled health services in the provision of earlier interventions into alcohol misuse, there are many other moments of contact between health professionals and Aboriginal clients which present opportunities for opening up dialogue on the issue of alcohol.

## **CHAPTER SEVEN**

---

### **Conclusion**

I set out at the beginning of this thesis to explore the reasons why indigenous people in Australia appear to have been insulated from national and international developments in the management of alcohol problems. I also wanted to examine whether some of the broader approaches to secondary prevention, which have emanated from, and are now being used by the wider population, would be feasible, acceptable and appropriate for indigenous people.

The politics of difference is central to this analysis of policies and practices in Aboriginal alcohol misuse. It had its foundations in the transformation of the pre- and post-war movement for equal, civil rights for Aboriginal people into the special, indigenous rights movement of the 1970s. This created the momentum for a number of important political and philosophical changes in the way in which indigenous people in Australia recognised themselves and demanded that the majority population recognise them. It was the catalyst for the mobilisation of the notion of cultural exceptionalism and difference, which has had far-reaching effects on the ways in which governments have dealt with indigenous people in this country. As it gathered momentum, indigenous politics developed simultaneously in domestic and international arenas, with Aboriginal representatives becoming adept at the politics of international embarrassment. Data on the poor health of Aborigines, life expectancies up to 18 years less than the majority population, and the over-representation of Aboriginal people in homicides, violence, imprisonment and alcohol-related problems were laid before an international audience. Simultaneously, useful networks were forged with other indigenous groups; Aboriginal activists travelled to Africa, China, the UK, Canada and the USA. Political changes in Australia brought new policies of self-determination and self-management at home, and

the Federal government began to take up its constitutional role by providing funds directly to 'community-controlled' Aboriginal non-government organisations.

The Aboriginal health movement which evolved in the early 1970s was established in order to provide primary health care to people who were not otherwise receiving any at all. Aboriginal health and other activists stressed their relationship with the Federal government. This was because it, not the State or Territory governments, is internationally accountable for the circumstances of its indigenous people and it funded separate community-controlled organisations directly, bypassing the State bureaucracies. These developments created a space within which indigenous people were able to build on notions of cultural regeneration and reaffirmation at home, and to utilise philosophical models of primary and participatory health care emanating from international organisations such as the World Health Organisation. I have argued that these developments had two broad impacts. Firstly, they allowed for a construction of cultural difference which has had an ongoing influence on conceptualisations of health and alcohol abuse, and on the orientation taken by Aboriginal community-controlled services to managing health and alcohol abuse. Secondly, they had a profound influence on the bureaucratic management of indigenous health matters.

The construction of cultural difference was promoted by indigenous people in Australia as elsewhere, as a means of explaining and rationalising their need for special treatment, which brought about a reversal of the situation in previous decades in which indigenous issues were actively suppressed. The idea of pan-indigenous conceptualisations of health - and as a corollary, community control of health services - was needed in order to shift the emphasis within Western medical practice towards greater sensitivity and awareness of Aboriginal needs. The discourse stressing fundamental cultural differences which often accompanied the debate over these matters, created a conceptual polarisation around the supposed characteristics of 'Western' and 'indigenous' world views as they applied to health. By depicting the dominant Western bio-medical orientation as the *only* Western model, indigenous 'holistic' conceptualisations became reified and were made exotic.

By offering a view which contests the assertions of an unproblematic indigenous homogeneity and of the existence of fundamental differences from the majority population, I run the risk of this deconstruction being construed as a political dismissal - dismissal of the existence of 'difference' at all, or denial of the need for community control. It is important to explain *why* indigenous health activists couched their arguments in these terms and during this period. While not contesting the existence of cultural differences, I have endeavoured to demonstrate that essentialist constructions of culture function as strategising devices which are often brought to bear in the context of the struggle for political power over the uneven distribution of resources. Ethnic or cultural difference may be artificially constructed for a number of political or social reasons but this does not mean that it is illegitimate, as Wilmsen has pointed out (Wilmsen and McAllister 1996). The invention and mobilisation of 'culture', and the application of these new conceptualisations of it, were necessary for indigenous people to claim their rightful share of national resources and to redirect these resources to services which stood the best chance of providing sympathetic and amenable health care to people who were otherwise grossly disadvantaged. Nonetheless, the politics of difference has had some unintended and unhelpful consequences.

These consequences included the responses of government. The politics of difference brought about a new sensitisation, and new uncertainties, at the level of the bureaucracy, which contributed to difficulties in policy- and decision-making which have had long-term ramifications.

While the Federal government increasingly allocated funds to indigenous organisations, there was also increasing caution and prevarication federally over where and how Aboriginal health issues were to be administered. There was considerable inter-departmental shifting of responsibility. In turn this created periods of administrative chaos with consequent loss of institutional memory and lack of specialised input into matters surrounding Aboriginal health. I argue that this affected the degree to which national policy-makers were able - and perhaps more importantly willing - to give

adequate coverage of indigenous issues in major national reports. National policies and programs sometimes failed to represent any substantial Aboriginal perspective at all, at a time when there was a need for policies, strategies and infrastructure development to take cognisance of advances in thinking about addiction, and to ascertain their relevance and applicability to indigenous people. There was a need to create channels through which new ideas could be communicated to Aboriginal alcohol programs, and to create opportunities for exchanges between alcohol professionals and grassroots workers. The development of numerous unlinked community-controlled health services meant that there were no consistent channels through which ideas - such as those of secondary prevention at the level of primary health care - could be disseminated.

The politics of difference also had its impact on the provision of services for Aboriginal alcohol problems. Tertiary residential programs were allowed to develop independently, unattached to either the health services or to State drug and alcohol units. Within these programs, and among many other alcohol spokespeople, the need to assert difference led Aboriginal people to emphasise (and biologise) their vulnerability, and to present their societies as having been colonised by the introduced disease of alcoholism. In this endeavour, they favoured the disease metaphor and were less sympathetic to suggestions that drinking patterns are learned and can be unlearned or relearned. In effect, an Aboriginal definition of alcoholism was arrived at. Alternative models and potentially fruitful 'mainstream' approaches were often dismissed as being culturally inappropriate, and there was no debate about the potential fit between harm minimisation and Aboriginal experiences. Insufficient attention to secondary prevention approaches allowed tertiary residential treatment to remain the dominant model of intervention provided to Aboriginal people with alcohol problems, rather than being one of several options.

Aboriginal people ended up having a more limited array of treatment options than other Australians. An analysis of some national policy documents, and the representations made to a major House of Representatives enquiry into Aboriginal alcohol abuse, indicates that some significant opportunities to rectify these matters were missed. These

missed opportunities were those which could have connected the Aboriginal alcohol organisations, programs and workers with new directions in, and approaches to, addiction. Although funding was available for reasons of historical precedent to many programs, these programs remained the 'poor relations' in Aboriginal health; they struggled with insufficient resources, lay or minimally trained staff who were usually ex-drinkers, and had little status. They had no overarching support or lobby group, and were dependent on the small network of strong ties with each other. These factors, and a failure of imaginative communication at home, drove Aboriginal alcohol activists offshore, to North America. There, among other indigenous people who shared similar backgrounds of colonisation and disadvantage, they found a welcome reinforcement of their belief in the power of culture as a form of healing, confirmation that indigenous people needed to control and run their own alcohol programs, and an external legitimisation of the goals of abstinence and the disease metaphor. The indigenous alcohol consultants from Canada and the United States encouraged an emphasis on the uses of 'culture' and spirituality, but they also transported an approach in which the basic elements were more North American than Native American. This raises important questions about the circumstances in which their not insubstantial influence occurred, considering that their guiding philosophies run counter to the policies and the orientation which have been pursued in Australia for two decades. The North American indigenous contacts were allowed to flourish unmonitored for a number of reasons. These were associated with belief in a universal 'nativism', an acute need on the part of Aboriginal alcohol workers for recognition and empowerment, and a response to fragmented funding.

There are several ironies in the way things worked out. One of these relates to the relative influence of WHO policies on health and alcohol problems. In the 1970s and 1980s WHO came to have considerable influence on Aboriginal health activists. They rightly interpreted the 1978 Declaration of Alma-Ata urging community control of and participation in health care, to be an endorsement of what Aboriginal people had themselves already set in process, through the birth of Aboriginal health services in the early 1970s. The emphasis on preventive health care and its delivery by community-

based health workers (inspired by the Chinese barefoot doctor program) was welcomed by the Aboriginal health movement, as was a de-emphasis of the medical model, bio-medicine and the primacy of doctors in health services. The broad WHO definition of health was the template against which Aboriginal people invented and constructed their own definitions. It was to provide one of the ideological underpinnings of arguments for special, 'culturally appropriate' services, and for a further elaboration of Aboriginal cultural difference from the mainstream population. The WHO, in conjunction with other UN agencies, also provided Aboriginal spokespeople with the opportunity to network and speak to an international audience.

Not all WHO edicts were taken up by the indigenous health movement. In the early 1980s WHO disavowed the narrow disease model, and proposed a broader, more holistic approach to alcohol, just as it had stressed the need for social, environmental and political answers rather than a reliance on bio-medicine to solve the world's health problems. WHO drew attention to the economic and political influences on alcohol misuse and proposed the need for early detection and intervention with harmful alcohol consumption: secondary prevention. The organisation funded a multi-centre international trial of brief interventions in alcohol misuse. It officially endorsed the findings of this study and continues to support international collaborations which produce state-of-the-art best practice reviews of alcohol policy. Unlike the impact of WHO's definition of health and its exegesis of primary health care, its pronouncements on the nomenclature of addiction, its expert committee mechanisms around alcohol and its support for the multi-centre cross-national study of brief interventions had no perceptible influence on the Aboriginal health and alcohol movements. In other words, Aboriginal health activists made only selective use of WHO. This could be for a number of reasons including the inevitable lag between policy and practice, or the fact that the findings of the WHO multi-centre trial and of best practice expert advice forums were disseminated in relatively academic, rather than popular, publications. The Aboriginal activists having most contact with WHO and the UN generally tend to be political or health lobbyists, rather than those engaged in substance abuse work, which may explain why the latest WHO position on alcohol prevention was not taken up. There was no clearing-house of indigenous knowledge on addiction, nor any umbrella

organisation with sufficient intellectual resources to take up ideas from such an international body. In addition, the Alma-Ata Declaration and subsequent refinements of primary health care had far more emotional sway and international exposure than the findings of groups of experts on addiction. All these interlocking reasons - and perhaps because the broader perspective on addiction urged by WHO simply did not *suit* Aboriginal constructions of the problem - may explain why they made no inroads into Aboriginal approaches to alcohol misuse.

It is also ironic that while WHO's holistic definition of health was taken up enthusiastically by *some* Aboriginal health activists (and canonised in the National Aboriginal Health Strategy), Aboriginal spokespeople working in the alcohol field maintained a disease-oriented, biologically-determined and decisively unitary model. A further significant feature here is the antipathy to harm minimisation as a policy approach to alcohol problems. Harm minimisation dovetails with the primary health care approach promulgated by WHO (and by Aboriginal health activists) because it seeks to replace arbitrary moralism with more pragmatic interventions, many of which can be community-based. It is remarkable, then, that the strong association between the primary health care philosophy and harm minimisation policies was not amplified - either by Aboriginal health activists, or by government agencies and policy-makers. Conceptualising harm minimisation for alcohol problems as being an integral part of primary, participatory health care would have been one way of reclaiming alcohol as an issue to be dealt with by those services, thus dislodging the exclusive focus on tertiary treatment of end-stage dependence.

### **The policy implications of this discussion**

There are two overall policy implications arising from this analysis. One is the need to broaden the range of interventions available for indigenous people with alcohol problems. The other is the need to expose indigenous organisations and personnel dealing with alcohol misuse to a more informed debate on these problems.

### **1) Broaden the range of interventions available**

This examination of existing approaches to dealing with Aboriginal alcohol problems, and the ways in which Aboriginal people sought to understand and define 'alcoholism', reveals a number of gaps in the successful communication of the intent and meaning of harm minimisation, and in the provision of secondary prevention.

I have said that attention has been directed to very early prevention or very late treatment for alcohol problems. The middle range of intervention - secondary prevention - has been neglected. This led me to consider the role of health professionals, particularly doctors, as deliverers of secondary preventions. I was also pointed in this direction as a result of my work with Aboriginal people who had recovered from dysfunctional drinking, and who attributed their change in behaviour, at least in part, to the influence of a doctor. Having suggested structural, bureaucratic and ideological reasons for the lack of attention paid to secondary prevention, I assessed the feasibility of doctors having a more pro-active role in the interruption of a pattern of hazardous or harmful drinking, and in prompting the motivation to change behaviour.

One way of delivering such secondary prevention is through the provision of brief interventions in primary health care, which are increasingly being used with members of the general population. It has not been possible to show unequivocally that such interventions will necessarily be influential with Aboriginal clients of health care services. However, it is possible to say that there seems to be no reason why Aboriginal clients should be any different to others in the community, as research into spontaneous remission suggests that they change their drinking behaviour for reasons that are very similar to everyone else. It is also possible that some features of these doctor-patient interactions are particularly congenial to Aboriginal people. This is because they are respectful of individual autonomy and decision-making, they provide a face-saving solution to the problem of pressure from drinking partners, and the status and respect enjoyed by doctors enhances their potential influence as the authorising, external Other who has the 'right' to dispense advice and expressions of concern. While none of these features are peculiar to indigenous people, they have a particular resonance with the social realities of daily life and the meanings of

drinking for them. However, there are still unresolved and potentially problematic issues to be considered. For example, in terms of the recipients of such interventions, there remains the problem that the majority of Aboriginal drinkers are harmful drinkers, and many are dependent drinkers who (according to the overall evidence) are less amenable to brief interventions. In terms of delivering the intervention, there may be political objections to highlighting the role of doctors in Aboriginal health services, in view of the fact that the history of the health movement was grounded in the ideology of participatory health and de-emphasis of the role of doctors.

Notwithstanding these caveats, in terms of disseminating this form of secondary prevention, indigenous people have numerous points of contact with primary health care. First and most obviously there are the community-controlled health services of which there are approximately 60 across the country. While there were only 27 doctors employed in such services in 1970, by 1995 there were 125 full time equivalent doctors employed by Aboriginal services (Deeble et al. 1998; Department of Prime Minister and Cabinet 1980). It is not known what proportion of the Aboriginal population actually use them although it would not be impossible to assess this (Australian Bureau of Statistics 1995; Deeble et al. 1998; Nathan 1980). Altogether, these services potentially have access to a significant proportion of the Aboriginal population living in all major cities and across rural and remote areas. Indigenous people also receive services from private general practitioners, Royal Flying Doctor Services, District Medical Officers, and many use out-patient emergency departments in hospitals as sources of primary health care. In the National Aboriginal and Torres Strait Islander survey, indigenous people were found to be three times more likely to use outpatients rather than going to a doctor, and we can conclude that hospital outpatient services are a key source of contact between Aborigines and medical staff. All these outlets then, are potential sites for the pro-active use of secondary prevention strategies, including brief interventions.

If these opportunities are to be used, the doctors or other health professionals involved need training in delivering different types of brief intervention. Training needs to sensitise doctors to the particular need of Aboriginal clients for non-authoritarian and flexible modes of

interaction around alcohol. Training would also need to direct the attention of the health professional to the fact that there is a greater orientation towards abstention in the Aboriginal community, while the decision about how to manage alcohol consumption rests ultimately with the client him or herself. The research material gathered for this study indicates that both doctors and clients need a 'good reason' to initiate discussion about the highly sensitive issue of alcohol consumption. This suggests that prior screening, or the existence of a relevant presenting health or social problem is important. In view of the recent re-direction of research attention to a focus on high-risk drinking (and away from lowering aggregate consumption), which I have identified as being particularly relevant for Aboriginal consumption patterns, brief interventions should be directed to high-risk individuals and occasions. We know that Aboriginal drinking patterns are largely bi-modal, and that they do not fit with the classic precepts of the 'prevention paradox'. If the target of the intervention is high-risk drinking, then it not only takes into consideration the prevalence of harmful (rather than moderate) drinking, but also the intervention would match current innovative thinking in the alcohol research field.

## **2) Facilitate an informed debate on alcohol misuse**

The other major policy implication of this research is the need to disseminate information about the different options for dealing with alcohol problems, and to facilitate a broader and more critical debate among indigenous treatment providers about models of addiction.

It is true that for the most part, the model of drinking which is most obvious from the experience of Aboriginal drinkers and in the orientation of treatment programs, is that of the 'overlearned' addictive behaviour: either dysfunctional abandoned drinking or abstinence. People have learned that there seem to be only these two patterns of behaviour. The very real existence of these extremes serves to insulate the Aboriginal community and the programs which service it from an openness to other ways of thinking about drinking. Powerlessness also has a place in these extremes, for the goal of abstinence assumes that people are so powerless over their drinking that the only solution is to stop altogether. It is likely that the wider experiences of personal and social

powerlessness among Aboriginal people function to reinforce their inclination towards an all-or-nothing pattern of consumption, which makes it more difficult to re-learn new patterns.

The individuals and organisations who have resisted the incorporation of approaches such as harm minimisation, controlled drinking, prevention, and the involvement of primary care services, are those whose careers and training have reinforced and maintained unitary understandings of Aboriginal drinking problems and the solutions to those problems. Dealing with these entrenched views requires the establishment of a professional network for Aboriginal alcohol programs which links them into existing drug and alcohol agencies, research centres, Aboriginal health services and State-based health units. Until now, this has been lacking. Workers in the Aboriginal programs need to receive regular in-service training offered by accredited training centres and which cover a wide range of approaches, not only those based on the Minnesota model. The involvement of professional bodies and exchanges with other agencies would help to curtail the presentation of the outdated and dubious pseudo-science which frequently characterises existing training courses for indigenous alcohol workers. Greater emphasis on tertiary training in addictions will expose more indigenous health professionals to the international debates on prevention and treatment and ultimately produce a cadre of workers able to contest different models of addiction. The committees and boards of Aboriginal services also need to be exposed to new ideas. The Commonwealth has taken steps in this direction, and has plans for an educational and awareness package for those Aboriginal lay people who sit on boards of management of residential programs.

Some of the policy implications arising from this work, especially those associated with the administrative home of Aboriginal health and substance abuse, appear to have been resolved, at least for the time being. Aboriginal health and substance abuse were relocated federally in July 1995 within the Commonwealth health portfolio in the Office of Aboriginal and Torres Strait Islander Health. Still unresolved, however, is the degree of linkage with other sections of the department still involved in indigenous issues. The role of the States and Territories is highly influential in that they contribute to the funding

of services. Some of the problems I identified related to the linkages between national programs (such as the National Drug Strategy) and their coverage of indigenous interests. I attributed these difficulties in part to the problems that national bodies have in dealing with Aboriginal separatism, as well as the absence of any non-aligned and broad-ranging expert advice emanating from the Aboriginal addictions field. These national programs should be required to devote as full and detailed attention to indigenous issues as those applied to other Australians. They have a responsibility to provide their best advice to indigenous programs and to establish mechanisms for this advice to be accessed. In turn, Aboriginal representative bodies have a responsibility to contribute to national drug and alcohol policy-making procedures and ensure that they provide reasoned and relevant contributions to them. In 1999 the Ministerial Council on Drug Strategy finally endorsed the establishment of a new National Drug Strategy Indigenous Australians' Reference Group which, in principle, could begin to address some of the shortcomings I mentioned. The Reference Group would be responsible for providing high level advice and expertise on priorities and strategies for specific drug issues to other national committees which were established as part of the National Drug Strategic Framework.

In the overall context of introducing a broader range of services to deal with indigenous alcohol problems, and in the specific context of providing secondary preventions such as brief interventions, the politics of difference masks two significant points. The first of these is that a number of Aboriginal problem drinkers manage to give up drinking on their own, sometimes with the encouragement of a health professional - just as others in the population do. This fact has salience for the potentially significant role of secondary prevention - the role of the health professional in motivating a decision to change. The politics of difference, in contrast, is associated with the perpetuation of a disempowering view of problem drinking which depicts Aboriginal people as being singled out by biology and history as the peculiar and helpless victims of forces beyond their control. The second significant point is that interventions devised for the wider 'mainstream' population nevertheless contain features which can be used as useful strategising mechanisms in culturally appropriate ways by indigenous people. The politics of difference would reject such mainstream innovations, by valorising 'culture' as being the

preferred technique for dealing with alcohol, and denying the existence of the many features of problem drinking which are shared by indigenous and non-indigenous people alike. The challenge is to provide a wide range of alcohol interventions which honour the autonomy and self-efficacy of the patient presenting with alcohol-related problems. These notions are important for all individuals - but they have particular salience for indigenous Australians.

## Bibliography

- Aboriginal and Torres Strait Islander Commission. 1992. The Australian Contribution to the UN Working Group on Indigenous Populations Tenth Session. Canberra: ATSIC.
- Aboriginal and Torres Strait Islander Commission. 1994a. The Australian Contribution to the UN Working Group on Indigenous Populations Twelfth session July 1994. Canberra: ATSIC.
- Aboriginal and Torres Strait Islander Commission (ATSIC). 1994b. Operational Plan 1993-1994. Canberra: ATSIC.
- Aboriginal Health Organisation of South Australia. 1989. Nunga's Access to Health Care in Adelaide. Metropolitan Health Needs Assessment Study. Adelaide: Aboriginal Health Organisation.
- Aboriginal Law Research Unit. 1985. UN Action on Aboriginal Rights. *Aboriginal Law Bulletin* 15 (August):1-2.
- Aboriginal Medical Service. 1991. New South Wales Aboriginal Mental Health Report. Sydney: Aboriginal Medical Service Redfern.
- Adler, M. 1991. From symbolic exchange to commodity consumption: anthropological notes on drinking as a symbolic practice. In *Drinking Behaviour and Belief in Modern History*, edited by S. Barrows and R. Room. Berkeley: University of California Press.
- Allam, L. 1993. Statement on behalf of the National Indigenous Youth Committee of Australia to the Working Group on Indigenous Populations, Eleventh Session. In *The Australian Contribution. UN Working Group on Indigenous Populations, 11th Session*, edited by Aboriginal and Torres Strait Islander Commission. Canberra: ATSIC.
- Allsop, S. 1990. Relapse prevention and management. *Drug and Alcohol Review* 9:143-153.
- ANCARD Working Party. 1997. The National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99. Canberra: Commonwealth Department of Health and Family Services, AGPS.
- Anderson, I. 1994a. Powers of health. *Arena Magazine* (June-July):32-36.
- Anderson, I. 1994b. Towards a Koori healing practice. In *Voices from the Land. 1993 Boyer Lectures*, edited by ABC. Sydney: Australian Broadcasting Corporation.

Anderson, I. 1997a. The National Aboriginal Health Strategy. In *Health Policy in Australia*, edited by H. Gardner. Melbourne: Oxford University Press.

Anderson, I. 1997b. I, the 'hybrid' Aborigine: film and representation. *Australian Aboriginal Studies* 107/number 1:4-14.

Anderson, I., and M. Brady. 1995. Performance indicators for Aboriginal Health Services. Canberra: Centre for Aboriginal Economic Policy Research, Australian National University.

Anderson, P. 1993. Management of alcohol problems: the role of the general practitioner. *Alcohol and Alcoholism* 28(3):263-272.

Anderson, P. 1996. *Alcohol and Primary Health Care*. Vol. 64. Copenhagen: WHO Regional Publications.

Andrews, B., F. Oates, and P. Naden. 1997. Smoking among Aboriginal health workers: findings of a 1995 survey in western New South Wales. *Australian and New Zealand Journal of Public Health* 21 (7):789-791.

Archibald, H.D. 1985. Foreword. In *Public Drinking and Public Policy*, edited by E. Single and T. Storm. Toronto: Addiction Research Foundation.

Ashley, M.J., and J. Rankin. 1988. A public health approach to the prevention of alcohol-related health problems. *Ann. Rev. Pub. Health* 9:233-271.

Attwood, B., and A. Markus. 1997. *The 1967 Referendum, or when Aborigines didn't get the vote*. Canberra: Aboriginal Studies Press.

Australian Bureau of Statistics. 1995. National Aboriginal and Torres Strait Islander Survey 1994. Canberra: Australian Government Printing Service.

Australian Institute of Health and Welfare. 1994. *Australia's Health 1994*. Canberra: AGPS.

Babor, T.F. 1994. Avoiding the Horrid and Beastly Sin of Drunkenness: Does Dissuasion make a difference? *Journal of Consulting and Clinical Psychology* 62 (6):1127-1140.

Babor, T.F., and M. Grant, eds. 1992. *Project on identification and management of alcohol-related problems. Report on Phase II: a randomized clinical trial of brief interventions in primary health care*. Edited by W. H. Organization. Geneva: World Health Organization.

Bain, M.S. 1974. Alcohol use and traditional social control in Aboriginal Society. In *Better Health for Aborigines?*, edited by B. S. Hetzel. St Lucia: University of Queensland Press.

Baker, J. 1989. Nunga's Access to Health Care in Adelaide. Metropolitan Health Needs Assessment Study. Adelaide: Aboriginal Health Organisation of South Australia.

Ballard, H.S. 1997. The hematological complications of alcoholism. *Alcohol Health and Research World* 21 (1):42-52.

Bandler, F. 1989. *Turning the Tide. A personal history of the Federal Council for the Advancement of Aborigines and Torres Strait Islanders*. Canberra: Aboriginal Studies Press.

Bandler, F, and L. Fox, eds. 1983. *The Time Was Ripe*. Chippendale, NSW: Alternative Publishing Co-op Ltd.

Barsh, R.L. 1984. Aboriginal rights, human rights, and international law. *Australian Aboriginal Studies* 1984/2:2-11.

Bartlett, B., and D. Legge. 1994. Beyond the Maze. Proposals for more effective administration of Aboriginal Health Programs. Canberra: Central Australian Aboriginal Congress and National Centre for Epidemiology and Population Health.

Batey, R.G., and G. Madsen. 1998. The carbohydrate-deficient transferrin test in hospital practice. *Drug and Alcohol Review* 17:105-109.

Beaton, N. 1994. Aboriginal health and a new curriculum for rural doctors. *Medical Journal of Australia (editorial)* 160:186-6.

Beckett, J. 1984. Comments on Robin Room's 'Alcohol and ethnography: a case of problem deflation?'. *Current Anthropology* 25 (2):169-191.

Beckett, J. 1985. 'Knowing how to talk to white people'. Torres Strait Islanders and the politics of representation. In *Indigenous Peoples and the Nation-State: 'Fourth World' Politics in Canada, Australia and Norway*, edited by N. Dyck. St Johns: Memorial University of Newfoundland.

Bennett, S. 1989. *Aborigines and Political Power*. Sydney: Allen and Unwin.

Bien, T.H., W.R. Miller, and J.S. Tonigan. 1993. Brief interventions for alcohol problems: a review. *Addiction* 88:315-336.

Billinghurst, B., and M. Whitfield. 1993. Why do patients change their general practitioner? A postal questionnaire study of patients in Avon. *British Journal of General Practice* August:336-338.

Blignault, I., and C. Ryder. 1997. Abstinence and alcohol use among urban Aborigines in Western Australia. *Drug and Alcohol Review* 16:365-371.

Bloom, A.L., ed. 1987. *Primary Health Care, Development Dossier No 20*. Canberra: Australian Council for Overseas Aid.

Brady, M. 1988. *Where The Beer Truck Stopped: Drinking in a Northern Australian Town, North Australia Research Unit Monograph*. Darwin: North Australian Research Unit.

Brady, M. 1991. Drug and alcohol use among Aboriginal people. In *The Health of Aboriginal Australia*, edited by J. Reid and P. Trompf. Sydney: Harcourt Brace Jovanovich.

Brady, M. 1992 . *Heavy Metal. The Social Meaning of Petrol Sniffing in Australia*. Canberra: Aboriginal Studies Press.

Brady, M. 1994. Vaccinating with Videos? A preliminary assessment of HIV/AIDS media strategies for Aboriginal and Torres Strait Islander people. Canberra: Department of Human Services and Health AIDS/Communicable Diseases Branch.

Brady, M., ed. 1995a. *Giving Away The Grog. Aboriginal accounts of drinking and not drinking*. Canberra: Drug Offensive, Commonwealth Department of Human Services and Health.

Brady, M. 1995b. Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous north Americans and Australians. *Social Science and Medicine* 41 (11):1487-1498.

- Brady, M. 1995c. Broadening the base of interventions for Aboriginal people with alcohol problems. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.
- Brady, M. 1998. *The Grog Book. Strengthening Indigenous Community Action on Alcohol*. Canberra: Commonwealth Department of Health and Family Services.
- Brady, M., S. Dawe, and R. Richmond. 1998. Expanding knowledge among Aboriginal service providers on treatment options for excessive alcohol use. *Drug and Alcohol Review* 17 (1):69-76.
- Brady, M. , and K. Palmer. 1984. *Alcohol In The Outback*. Darwin: North Australia Research Unit.
- Brennan, F. 1991. *Sharing the Country. The case for an agreement between black and white Australians*. Ringwood, Vic: Penguin.
- Briceno-Leon, R. 1993. Social aspects of Chagas disease. In *Knowledge, Power and Practice. The Anthropology of Medicine and Everyday Life*, edited by S. Lindenbaum and M. Lock. Berkeley: University of California Press.
- Burden, J. 1994. Health: a holistic approach. In *Aboriginal Australia: An Introductory Reader in Aboriginal Studies*, edited by C. Bourke, E. Bourke and B. Edwards. St Lucia: University of Queensland Press.
- Burman, S. 1997. The Challenge of Sobriety: Natural Recovery without Treatment and Self-Help Groups. *Journal of Substance Abuse* 9:41-61.
- Caldwell, J., and P Caldwell. 1995. Synthesis: where are we now? (Forum: Can health transition research improve health?). *Health Transition Review* 5 (2):254-258.
- Carroll, J., and B. Wilson. 1984. Benelong's Haven celebrates its tenth anniversary. *Aboriginal Health Worker Journal* 8 (4):25-26.
- Chegwidden, M., and B.J. Flaherty. 1977. Aboriginal versus non-Aboriginal alcoholics in an alcohol withdrawal unit. *Medical Journal of Australia* (7 May):699-703.

- Chen, R., R.P. Mattick, and A Baillie. 1993. Clients of Treatment Service Agencies. March 1992 Census findings. Canberra: Department of Health, Housing, Local Government and Community Services, Australian Government Publishing Service.
- Chick, J. 1993. Brief interventions for alcohol misuse. *British Medical Journal* 307 (27 November):1374.
- Combined Central Australian Health Services. 1989. The Visual AIDS Project. Alice Springs: Congress.
- Commonwealth Department of Health and Family Services. 1998. Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Programme. Canberra: Department of Health and Family Services.
- Commonwealth Department of Human Services and Health. 1994. National Drug Strategy Household Survey. Urban Aboriginal and Torres Strait Islander Peoples Supplement. Canberra: Commonwealth Department of Human Services and Health.
- Commonwealth of Australia. 1988. AIDS: A Time to Care A Time to Act. Towards a strategy for all Australians. Canberra: AGPS.
- Coombs, H.C., M.M. Brandl, and W.E. Snowdon. 1983. *A Certain Heritage. Programs for and by Aboriginal families in Australia, CRES Monographs*. Canberra: Australian National University.
- Couzos, S., and R. Murray. 1999. *Aboriginal Primary Health Care. An Evidence-based Approach*. Melbourne: Oxford University Press.
- Cumpston, J.H.L., and M.J. Lewis. 1989. *Health and Disease in Australia. A History*. Canberra: AGPS.
- d'Abbs, P. 1995. The power of kava or the power of ideas? Kava use and kava policy in the Northern Territory, Australia. *Canberra Anthropology* 18 (1/2):166-182.
- d'Abbs, P., S. Togni, and I. Crundall. 1996. The Tennant Creek Liquor Licensing Trial, August 1995-February 1996: An Evaluation. Darwin: Menzies School of Health Research.
- Davis, J. 1998. Alcohol and Aboriginal Society: Is Racism Dead in the Alcohol and Drug Field? In *Drug Use in Australia. A Harm Minimisation Approach*, edited by M. Hamilton, A. Kellehear and G. Rumbold. Melbourne: Oxford University Press.

- Dawe, S., and R. Richmond. 1997. Controlled drinking as a treatment goal in Australian alcohol treatment agencies. *Journal of Substance Abuse Treatment* 14:1-6.
- Deeble, J., C. Mathers, L. Smith, J. Goss, R. Webb, and V. Smith. 1998. Expenditures on Health Services for Aboriginal and Torres Strait Islander People. Canberra: Australian Institute of Health and Welfare.
- Deloria, V. 1976. The Red and the Black. *Identity* April:36-37.
- Department of Community Services and Health. 1988. *World Health Organization. A brief summary of its work*. Canberra: AGPS.
- Department of Community Services and Health. 1989. National HIV/AIDS Strategy. Canberra: AGPS.
- Department of Community Services and Health. 1991. AIDS Education: the Next Three Years. Canberra: Department of Community Services and Health.
- Department of External Affairs. 1964. The Australian Aborigines. Canberra: AGPS.
- Department of Health Housing and Community Services. 1992. A Report on HIV/AIDS Activities in Australia 1990-91. Canberra.
- Department of Human Services and Health. 1994. Better Health Outcomes for Australians. Canberra: AGPS.
- Department of Prime Minister and Cabinet. 1980. Program Effectiveness Review: Aboriginal Health. Canberra: Commonwealth of Australia.
- Devanesen, D., and J. Briscoe. 1980. The Health Worker Training Programme in Central Australia. Paper read at The Lambie-Dew Oration 1980, at Sydney University Medical Society.
- Devitt, J., and A. McMasters. 1998a. *Living on Medicine. A cultural study of end-stage renal disease among Aboriginal people*. Alice Springs: Institute of Aboriginal Development Press.
- Director-General WHO. 1997. The World Health Report 1997. Conquering suffering Enriching humanity. Geneva: WHO.

- Ditton, P. 1990. 'Self determination' or 'self management'? *Australian International Law News*:3-12.
- Dodd, M. 1981. Aboriginal health delegation to China, July 1981. *Aboriginal Health Worker Journal* 5 (4):38-39.
- Dodson, M. 1995. Aboriginal and Torres Strait Islander Social Justice Commissioner Second Report 1994. Canberra: Human Rights and Equal Opportunity Commission, AGPS.
- Donovan, D.M. 1988. Assessment of addictive behaviours. Implications of an emerging biopsychosocial model. In *Assessment of Addictive Behaviours*, edited by D. M. Donovan and G. A. Marlatt. New York: Guilford Press.
- Drew, L.R.H. 1977. Changes in Australian drinking patterns: 1969-1976. *Australian Journal of Alcoholism and Drug Dependence* 4 (3):78-80.
- Drew, L.R.H. 1986. Beyond the disease concept of addiction: drug use as a way of life leading to predicaments. *Journal of Drug Issues* 16 (2):263-274.
- Dubos, R. 1959. *Mirage of Health. Utopias, Progress and Biological Change*. New York: Harper and Bros.
- Dubos, R. 1969. Human ecology. *WHO Chronicle* 23 (11):499-504.
- Dubos, R. 1970. *Man, Medicine, and Environment*. Ringwood, Vic: Penguin.
- Duguid, C. 1978. *No Dying Race*. Adelaide: Rigby.
- Duran, E., and B. Duran. 1995. *Native American Postcolonial Psychology*. Albany: State University of New York Press.
- Durie, M. 1994. *Whairoa. Maori Health Development*. Auckland: Oxford University Press.
- Dyck, N., ed. 1985. *Indigenous Peoples and the Nation-State: 'Fourth World' politics in Canada, Australia and Norway*. St Johns , Newfoundland: Institute of Social and Economic Research, Memorial University of Newfoundland.

Edwards, G, and and 16 other authors. 1995. *Alcohol Policy and the Public Good*, Oxford Medical Publications. Oxford: Oxford University Press and WHO.

Elkin, A.P. 1977. *Aboriginal Men of High Degree*. 2nd ed. St Lucia, Qld: University of Queensland Press.

Elvy, G. 1989. An overview: the issues and the National Alcohol Policy. Paper read at Alcohol and Crime, 1990, at Perth.

Engel, G. 1977. The need for a new medical model: a challenge to biomedicine. *Science* 196 (4286):129-136.

Ernst and Young. 1996. Review of Long Term Residential Treatment for People with Alcohol and Other Drug Use Problems. Canberra: Drugs of Dependence Branch, Commonwealth Department of Human Services and Health.

Etzioni, A. 1993. The evils of self determination. *Foreign Policy* Winter:21-35.

Fagan, P. 1991. Self-determination in action. In *The Health of Aboriginal Australia*, edited by J. C. Reid and P. Trompf. Marrickville, NSW: Harcourt, Brace, Jovanovich.

Flannery, T., ed. 1996. 1788. *Watkin Tench. Comprising A Narrative of the Expedition to Botany Bay and A Complete Account of the Settlement at Port Jackson*. Melbourne: Text Publishing Co.

Fleming, K., and D. Devanesen. 1985. Health policies and the development of Aboriginal self management in the Northern Territory. Paper read at First International Regional Management Conference, Asia-Australia-Pacific, at Darwin.

Fleming, M.F. et al. 1997. Brief physician advice for problem alcohol drinkers: a randomized controlled trial in community-based primary care practices. *Journal of the American Medical Association* 277:1039-1045.

Flick, B., and B. Nelson. 1994. Land and Indigenous Health. *Land, Rights, Laws: Issues of Native Title* Issues paper no.3.

Folds, R. 1985. Constraints on the role of Aboriginal Health and Education Workers as Community Developers. *Australian Journal of Social Issues* 20 (3):228-233.

Foley, G. 1975. The History of the Aboriginal Medical Service. A study in bureaucratic obstruction. *Identity* July:38-40.

Foley, G. 1982. Aboriginal community-controlled health services - a short history. *Aboriginal Health Project Information Bulletin* 2 (August):13-15.

Foster, G.M. 1965. *Traditional Cultures: and the impact of technological change*. Evanston and London: Harper and Row.

Frape, G., P. Mills, P. Sago, and G. Smallwood. 1988. Community action: a cooperative approach to Aboriginal-Islander workshops to develop materials on drug and alcohol and AIDS information. *Aboriginal Health Worker Journal* 12 (2):44-47.

Fua, C. 1987. Aboriginal Programmes, Queensland. *Australian Drug and Alcohol Review Suppl.1*.

Gallois, C., D. Statham, and S. Smith. 1992. Women and HIV/AIDS Education in Australia. Canberra: Commonwealth Department of Health Housing and Community Services.

Gardiner-Garden, J. 1994. Innovation without change? Commonwealth involvement in Aboriginal health policy. Canberra: Parliamentary Research Service.

Goldman, L. 1991. *Handbook on Alcohol and other Drug Problems for Medical Practitioners*. Edited by T. D. Offensive. Canberra: Australian Government Publishing Service.

Goodall, H. 1996. *Invasion to Embassy. Land in Aboriginal Politics in New South Wales, 1770-1972*. St Leonards, NSW: Allen & Unwin.

Gordon, C, ed. 1980. *Power/Knowledge. Selected Interviews and Other Writings 1972-1977 Michel Foucault*. Brighton: The Harvester Press.

Gordon, S. 1994. The National Aboriginal Health Strategy: an evaluation. Canberra: ATSIC.

Gossop, M., and M. Grant. 1990. *Preventing and controlling drug abuse*. Edited by WHO. Geneva: World Health Organization.

Granovetter, M. 1973. The Strength of Weak Ties. *American Journal of Sociology* 78 (6):1360-1380.

- Granovetter, M. 1983. The strength of weak ties: a network theory revisited. In *Sociological Theory*, edited by R. Collins. San Francisco: Jossey-Bass.
- Gray, A. 1995. The indigenous movement in Asia. In *Indigenous Peoples of Asia*, edited by R. H. Barnes, A. Gray and B. Kingsbury. Ann Arbor: Association for Asian Studies.
- Gray, D. 1980. Traditional Medicine on the Carnarvon Aboriginal Reserve. In *Aborigines of the West. Their Past and Their Present*, edited by R. M. Berndt and C. H. Berndt. Perth: University of Western Australia Press.
- Green, R.K. 1980. Aborigines and international politics. In *Aborigines of the West. Their Past and their Present*, edited by R. M. Berndt and C. H. Berndt. Perth: University of Western Australia Press.
- Griew, R. 1996. A strong commitment to improve Aboriginal and Torres Strait Islander Health. *Aboriginal and Islander Health Worker Journal* 20 (2):53-55.
- Gureje, O., V. Mavreas, J.L. Vazquez-Barquero, and A. Janca. 1997. Problems related to alcohol use: a cross-cultural perspective. *Culture, Medicine and Psychiatry* 21:199-211.
- Harding Burns, F., and D.R. Sullivan. 1983. Case study: intervention in alcohol abuse in Aboriginals - the viewpoint of the uninitiated. *Australian Alcohol/Drug Review* 2 July (2):121-122.
- Harris, S. 1979. *It's Coming Yet...An Aboriginal Treaty within Australia Between Australians*. Canberra: The Aboriginal Treaty Committee.
- Hawks, D. 1989. The watering down of Australia's health policy on alcohol. Paper read at Winter School in the Sun, 1989, at Brisbane.
- Hazlehurst, K.M. 1994. *A Healing Place. Indigenous Visions for Personal Empowerment and Community Recovery*. Rockhampton: Central Queensland University.
- Health Targets and Implementation Committee. 1988. *Health for All Australians*. Canberra: Department of Community Services and Health.
- Heath, D.B. 1987. A decade of development in the anthropological study of alcohol use, 1970-1980. In *Constructive Drinking:perspectives on drink from anthropology*, edited by M. Douglas. Cambridge: Cambridge University Press.

Hennessy, C. 1981. Running an alcohol rehab. centre: some problems. *Aboriginal Health Worker* 5 (3):47-50.

Herron, J. 1999. The Future of Indigenous Health Care - the Union of Body and Soul: Queensland Branch of the Australian Medical Association.

Hiatt, L. R. 1997. A New Age for an Old People. *Quadrant* June : 35-40.

Hiatt, L.R. 1998. Mutant Message Down Under: A New Age for an Old People.

In *Approaching Australia: Papers from the Harvard Australian Studies Symposium*, edited by H. Bolitho and C. Wallace-Crabbe. Cambridge, Massachusetts: Harvard University Press.

Higgins-Biddle, J.C., and T.F. Babor. 1996. *Reducing Risky Drinking. A report on early identification and management of alcohol problems through screening and brief intervention*. Farmington: Alcohol Research Centre, University of Connecticut.

Hill, P. 1996. Reading the Phantom in Condoman: Semiotics in Health Promotion. *Health Promotion Journal of Australia* 6 (1):32-7.

Hill, P.S., and G.J. Murphy. 1992. Cultural identification in Aboriginal and Torres Strait Islander AIDS education. *Australian Journal of Public Health* 16 (2):150-157.

Hobsbawm, E. 1996. Introduction: Inventing Traditions. In *The Invention of Tradition*, edited by E. Hobsbawm and T. Ranger. Cambridge: Cambridge University Press.

Hodgson, Maggie. 1996. 'Body, Mind and Spirit': Native community addictions, treatment and prevention. In *Popular Justice and Community Regeneration. Pathways of Indigenous Reform*, edited by K. M. Hazlehurst. Wesport, Conn.: Praeger.

Hogg, R.S. 1995. Aboriginal and non-Aboriginal mortality in rural Australia. *Human Organization* 54 (2):214-221.

Holding, C. 1985. Aboriginal health issues. *Medical Journal of Australia* 143 (October 28):S42-S43.

Horner, J. 1994. *Bill Ferguson: fighter for Aboriginal freedom*. 2nd ed. Canberra: Author, GPO Box 1074 Canberra.

House of Representatives Standing Committee on Aboriginal Affairs. 1977. Alcohol Problems of Aboriginals. Final Report. Canberra: AGPS.

House of Representatives Standing Committee on Aboriginal Affairs. 1979. Aboriginal Health. Canberra: Commonwealth of Australia.

House of Representatives Standing Committee on Aboriginal Affairs. 1993. Access and Equity - Rhetoric or Reality? Report of the Inquiry into the Implementation of the Access and Equity Strategy. Canberra: AGPS.

HRSCAA. 1976-1977. House of Representatives Standing Committee on Aboriginal Affairs. Reference: Alcohol Problems of Aborigines Official Hansard Report. Canberra: Australian Parliament.

Hughes, J. 1994. Medical anthropology and international health. In *Anthropology and Third World Development*, edited by B. Geddes, J. Hughes and J. Remenyi. Geelong, Vic: Deaking University Press.

Human Rights and Equal Opportunity Commission. 1997. Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families. Canberra: Human Rights and Equal Opportunity Commission, AGPS.

Humphreys, K., R.H. Moos, and J.W. Finney. 1995. Two Pathways out of Drinking Problems Without Professional Treatment. *Addictive Behaviors* 20 (4):427-441.

Hunt, H. 1984. Alcoholism among Aboriginal people. *Aboriginal Health Worker* 8 (4):11-14.

Hunter, E. 1992. Aboriginal alcohol use - a review of quantitative studies. *Journal of Drug Issues* 22 (3):713-731.

Hunter, E. 1993. *Aboriginal Health and History. Power and prejudice in remote Australia*. Cambridge: Cambridge University Press.

Hunter, E., M. Brady, and W. Hall. 1999. National Recommendations for the Clinical Management of Alcohol-related problems in Indigenous Primary Care Settings. Cairns: University of Queensland, Tropical Public Health Unit.

- Hunter, E., W. Hall, and R. Spargo. 1991. Distribution and correlates of alcohol consumption in a remote Aboriginal population. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.
- Hutt, M., and P. Howden-Chapman. 1998. *Old Wine in New Bottles. The Public Health Commission and the Making of New Zealand Alcohol Policy*. Vol. Public Health Monograph Series no 3. Wellington: Department of Public Health, Wellington School of Medicine.
- Ikin, D. 1999. 'Milliya Rumurra-Brand New Day'. *Aboriginal and Islander Health Worker Journal* 23 (1):11-14.
- Illich, I. 1975. *Medical Nemesis. The Expropriation of Health*. London: Calder & Boyars Ltd.
- Institute of Medicine. 1990. *Broadening the base of treatment for alcohol problems. Report of a study by a committee of the Institute of Medicine*. Washington, DC: National Academy Press.
- Jilek, W.G. 1988. *Indian Healing. Shamanic Ceremonialism in the Pacific Northwest Today*. Surrey, BC.: Hancock House Publishers Ltd.
- Johansson, S.R. 1995. Health transition research, health policy and human welfare. *Health Transition Review* 5 (2):227-230.
- Johnson, B. 1990. *Ojibway Heritage. The ceremonies, rituals, songs, dances, prayers and legends of the Ojibway*. Toronto: McLelland and Stewart Inc.
- Johnston, E. 1991. Royal Commission into Aboriginal Deaths in Custody. Final Report. Canberra: AGPS.
- Jurd, S. 1994. Is in-patient treatment justified for alcohol dependence? *Drug and Alcohol Review* 13:203-207.
- Kahn, M.V., and C. Fua. 1992. Counselor training as a treatment for alcoholism: the helper therapy principle in action. *International Journal of Social Psychiatry* 38 (3):208-214.
- Kalokerinos, A. 1974. *Every Second Child*. Melbourne: Thomas Nelson (Australia) Ltd.
- Kalokerinos, A. nd. Alcohol and Australian Aborigines. Sydney: Aboriginal Medical Service Information Service, Redfern.

- Kamien, M. 1975a. Cultural chasm and chaos in the health care services to Aborigines in rural New South Wales. *Medical Journal of Australia* 2 (Special supplement):6-11.
- Kamien, M. 1975b. Aborigines and Alcohol. Intake, effects and social implications in a rural community in western New South Wales. *Medical Journal of Australia* March 8:291-297.
- Kamien, M. 1978. *The Dark People of Bourke. A study of planned social change*. Canberra: Australian Institute of Aboriginal Studies.
- Katz, R. 1982. *Boiling Energy. Community Healing among the Kalahari Kung*. Cambridge, Mass.: Harvard University Press.
- Kingdon, T. 1993. The relevance of research to policy formulation: an Australian perspective. *Addiction* 88 (Supplement):61S-65S.
- Kingsbury, B. 1995. Indigenous peoples' as an international legal concept. In *Indigenous Peoples of Asia*, edited by R. H. Barnes, A. Gray and B. Kingsbury. Ann Arbor: Association for Asian Studies.
- Kirke, K. 1969. Correspondence to Ass.Dir. Southern Region: Commonwealth Department of Health.
- Kirke, K., C. Divakaran-Brown, K. Priest, and D. Roder. 1993. South Australian Health Statistics Chart Book. Supplement 4: Aboriginal health. Adelaide: South Australian Health Commission.
- Klingemann, H.K.H. 1991. The motivation for change from problem alcohol or heroin use. *British Journal of Addiction* 86:727-744.
- Kohn, M. 1996. *The Race Gallery. The Return of Racial Science*. London: Vintage, Random House.
- Kreitman, N. 1986. Alcohol consumption and the preventive paradox. *British Journal of Addiction* 81:353-364.
- Kue Young, T. 1988. *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*. Toronto: Toronto University Press.
- Kunitz, S.J. 1994. *Disease and Social Diversity. The European Impact on the Health of Non-Europeans*. New York: Oxford University Press.

- Kunitz, S.J., and M. Brady. 1995. Health care policy for Aboriginal Australians: the relevance of the American Indian experience. *Australian Journal of Public Health* 19 (6):549-558.
- Kunitz, S.J., and J.E. Levy. 1995. Health transition research and the adoption of innovation. *Health Transition Review* 5 (2 October):234-238.
- Lake, P. 1989. Alcohol and cigarette use by urban Aboriginal people. *Aboriginal Health Information Bulletin* 11 (May):20-22.
- Langton, M. 1993. Rum, seduction and death. Aboriginality and alcohol. *Oceania* 63 (3):195-206.
- Lee, S. 1997. WHO and the developing world: the contest for ideology. In *Western Medicine as Contested Knowledge*, edited by A. Cunningham and B. Andrews. Manchester: Manchester University Press.
- Levin, M.D., ed. 1993. *Ethnicity and Aboriginality: case studies in ethnonationalism*. Toronto: University of Toronto Press.
- Levy, J.E., and S.J. Kunitz. 1981. Economic and political factors inhibiting the use of basic research findings in Indian alcoholism programs. *Journal of Studies on Alcohol*, Suppl.9:60-72.
- Lewis, G. 1986. Concepts of health and illness in a Sepik society. In *Concepts of Health, Illness and Disease. A comparative perspective*, edited by C. Currer and M. Stacey. Leamington Spa: Berg.
- Lewis, J.R. 1994. Patient Views on Quality Care in General Practice: Literature Review. *Social Science and Medicine* 39 (5):655-670.
- Lewis, M. 1988. Alcoholism in Australia, the 1880s to the 1980s: from medical science to political science. *Australian Drug and Alcohol Review* 7:391-401.
- Lewis, M. 1992a. *A Rum State. Alcohol and State Policy in Australia 1788-1988*. Canberra: AGPS.
- Lewis, M. 1992b. Treatment of alcoholism in Australia from the 1950s to the 1980s. *Journal of Drug Issues* 22 (3):607-624.
- Lupton, D. 1994. *Medicine as Culture. Illness, disease and the body in Western societies*. London: Sage Publications.

Lyon, P. 1991. Liquor licensing, Aborigines and take away alcohol in Central Australia. *Aboriginal Law Bulletin* August:11-13.

Macdonald, G. 1993. Aboriginal and Ainu Rights:the struggle goes international. In *Indigenous Minorities and Education. Report of Joint Research Project James Cook University of N. Queensland and Hokkaido University of Education*, edited by N. Loos and T. Osanai. Tokyo: Sanyusha Publishing Co.

MacDonald, R. 1995. *Between Two Worlds. The Commonwealth government and the removal of Aboriginal children of part descent in the Northern Territory*. Alice Springs: IAD Press.

Maher, C., and E. Tilton. 1994. Health Promotion or Self Promotion? A Central Australian Aboriginal Alcohol Media Strategy. Alice Springs: Central Australian Aboriginal Congress.

Major, C. 1994. The front line. *Connexions* April/May:6-11.

Marcus, A. 1978. Talka Longa Mouth:Aborigines and the Labor movement 1890-1970. In *Who Are Our Enemies? Racism and the Working Class in Australia*, edited by A. Curthoys and A. Marcus. Neutral Bay, NSW: Hale and Ironmonger.

Markey, P. 1996. The prevalence of ischaemic and rheumatic heart disease and risk factors in Aboriginal and non-Aboriginal footballers. MPH thesis, Department of Community Medicine, University of Adelaide, Adelaide.

Marshall, M. 1979. *Weekend Warriors. Alcohol in a Micronesian Culture*. Palo Alto: Mayfield Publishing Company.

Marshall, M., ed. 1982. *Through a Glass Darkly. Beer and modernization in Papua New Guinea*. Boroko, Papua New Guinea: Institute of Applied Social and Economic Research.

Marshall, M. 1985. Social thought, cultural belief and alcohol. *Journal of Drug Issues* 15 (1):63-71.

Marshall, M. 1990. 'Problem deflation' and the ethnographic record: interpretation and introspection in anthropological studies of alcohol. *Journal of Substance Abuse* 2:353-367.

Martin, D.F. 1993. Autonomy and Relatedness. PhD, Dept of Prehistory and Anthropology, Australian National University, Canberra.

Martin, D.F. 1998. The supply of alcohol in remote Aboriginal communities: potential policy directions from Cape York. Canberra: Centre for Aboriginal Economic Policy Research, Australian National University.

Mattick, R.P., and T. Jarvis. 1993. An Outline for the Management of Alcohol Problems. Quality assurance in the treatment of drug dependence project. Canberra: National Drug Strategy, AGPS.

Mattick, R.P., and T. Jarvis. 1994a. Brief or minimal intervention for 'alcoholics'? The evidence suggests otherwise. *Drug and Alcohol Review* 13:137-144.

Mattick, R.P., and T. Jarvis. 1994b. In-patient setting and long duration for the treatment of alcohol dependence? Outpatient care is as good. *Drug and Alcohol Review* 13:127-135.

McKnight, D. 1986. Fighting in an Australian Aboriginal supercamp. In *The Anthropology of Violence*, edited by D. Riches. Oxford: Basil Blackwell.

McMasters, A. 1996. Research from an Aboriginal health worker's point of view. *Australian and New Zealand Journal of Public Health* 20 3:319-320.

Middleton, M.R., and S.H. Francis. 1976. *Yuendumu and its Children. Life and health on an Aboriginal Settlement*. Canberra: AGPS.

Miller, K., and T. Rowse. 1995. CAAAPU: an evaluation. Darwin: Menzies School of Health Research.

Miller, W.R. 1991. Emergent treatment concepts and techniques. *Annual Review of Addictions Research and Treatment* 1:283-296.

Miller, W.R., and E. Kurtz. 1994. Models of alcoholism used in treatment: contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol* 55 (2):159-166.

Milner, G. 1973. Drug abuse, alcohol and marihuana problems. Errors, costs and concepts. *Medical Journal of Australia* August 11:285-290.

- Mobbs, R. 1991. In sickness and health: the sociocultural context of Aboriginal well-being, illness and healing. In *The Health of Aboriginal Australia*, edited by J. Reid and P. Trompf. Sydney: Harcourt, Brace Jovanovic h.
- Mohr, R., E. Schaber, and H. Whitty. nd. An evaluation of Bushwize and Shelter Me Comics produced by Streetwize. Sydney: Streetwize Comix.
- Moodie, P.M. 1973. *Aboriginal health*. Canberra: Australian National University Press.
- Mosey, A. 1994. Central Australian Remote Area Aboriginal Night Patrols. A Review. Alice Springs: Drug and Alcohol Services Association.
- Moynihan, D.P. 1994. *Pandaemonium: Ethnicity in International Politics*. Oxford: Oxford University Press.
- Mull, J.D. 1990. The Primary Health Care dialectic: history, rhetoric and reality. In *Anthropology and Primary Health Care*, edited by J. Coreil and J. D. Mull. Boulder: Westview Press.
- Murray, C.J.L., and L.C. Chen. 1994. Understanding morbidity change. In *Health and Social Change in International Perspective*, edited by L. C. Chen, A. Kleinman and N. C. Ware. Boston: Harvard University Press.
- R.*
- Myers, F.R. 1988. The logic and meaning of anger among Pintupi Aborigines. *Man (N.S.)* 23 (4):589-610.
- Myers, F.R. 1986. *Pintupi Country, Pintupi Self*. Washington, London: Smithsonian Institute Press.
- Nathan, P. 1980. *A Home Away from Home. A study of the Aboriginal Health Service in Fitzroy, Victoria*. Bundoora: Pit Press, Preston Institute of Technology.
- Nathan, P., and D.L. Japanangka. 1983. *Health Business*. Victoria: Heinemann Education Australia.
- National Aboriginal Health Strategy Working Party. 1989. National Aboriginal Health Strategy. Canberra: no publisher listed.
- National Campaign Against Drug Abuse. 1985. National Campaign Against Drug Abuse. Campaign document issued following the Special Premier's Conference. Canberra: Department of Health, AGPS.

National Campaign Against Drug Abuse Task Force on Evaluation. 1988. National Campaign Against Drug Abuse 1985-1988. Report of the NCADA Task Force on Evaluation to the Ministerial Council on Drug Strategy. Canberra.

National Centre for Epidemiology and Population Health. 1992. Improving Australia's Health. The Role of Primary Health Care. Final report of the review of the role of primary health care in health promotion in Australia. Canberra: Australian National University.

National Drug Strategy Committee. 1993. National Drug Strategic Plan 1993-97. Canberra: AGPS.

National Evaluation Steering Committee. 1993. Report of the Evaluation of the National HIV/AIDS Strategy. Canberra: Department of Health Housing and Community Services.

National Institute on Alcohol Abuse and Alcoholism. 1999. Brief Interventions for Alcohol Problems. *Alcohol Alert* 43 (April):1.

Newfong, J. 1989. AIDS and Aborigines. The plague and persecution. *Aboriginal Medical Service Newsletter* June:3-4.

Nganampa Health Council. 1988. Annual Report 1986-1987. Alice Springs: Nganampa Health Council.

Northern Territory Department of Health. 1980. Annual Health Workers Conference. Paper read at Annual Health Workers Conference, 1980, at Alice Springs.

Northern Territory Department of Health. 1982. Annual Report 1981/1982. Darwin: NT Health.

Northern Territory Division. 1977. Aboriginal Health Worker Training Programme in the Northern Territory. A report of the work carried out by the Education and Training Task Force November 1976 to June 1977. Darwin: Commonwealth Department of Health.

Nutbeam, D., M. Wise, A. Bauman, E. Harris, and S. Leeder. 1993. Goals and Targets for Australia's Health in the year 2000 and Beyond. Sydney: Department of Public Health, University of Sydney.

O'Connor, R. 1988. Report on the Aboriginal Alcohol Treatment/Rehabilitation Programmes Review and Consultation. Perth: WA Alcohol and Drug Authority.

Office of Evaluation and Audit. 1996. ATSIC Substance Abuse Evaluation Report. Canberra: ATSIC.

Orford, J. 1992. Control, confront or collude: how family and society respond to excessive drinking. *British Journal of Addiction* 87:1513-1525.

PAHO. 1993. Development and Strengthening of Local Health Systems. Resolution V. Health of Indigenous People. Washington DC: Pan American Health Organization, Regional Office of WHO.

Pearson, G. 1987. *The New Heroin Users*. Oxford: Basil Blackwell.

Perkins, C. 1975. *A Bastard Like Me*. Sydney: Ure Smith.

Perkins, J.J., R.W. Sansom-Fisher, S. Blunden, D. Lunnay, S. Redman, and M.J. Hensley. 1994. The prevalence of drug use in urban Aboriginal communities. *Addiction* 89:1319-1331.

Perkins, N. 1974. The Central Australian Aborigines Congress. An expression of Pan-Aboriginalism and Aboriginal Self-Determination. *Identity* (July):27-32.

Petersen, A.R. 1985. The prevention of alcohol problems in Australia: origin and implementation of policy. In *Alcohol and Drug Use in a Changing Society. Second National Drug Institute*, edited by K. P. Larkins, D. McDonald and C. Watson. Canberra: Alcohol and Drug Foundation, Australia.

Peterson, N. 1993. Demand sharing: reciprocity and the pressure for generosity among foragers. *American Anthropologist* 95 (4):860-874.

Peterson, N. 1999. Hunter-Gatherers in First World Nation States: Bringing Anthropology Home. *Bulletin of the National Museum of Ethnology (Osaka)* 23 (4):847-861.

Plant, M., E. Single, and T. Stockwell. 1997. *Alcohol. Minimising the Harm. What Works?* London/New York: Free Association Books.

Pomare, E., V. Keefe-Ormsby, C. Ormsby, N. Pearce, P. Reid, B. Robson, and N. Watene-Haydon. 1995. *Hauora. Maori Standards of Health III*. Wellington South: Eru Pomare Maori Health Research Centre, Wellington School of Medicine.

Powell, A. 1988. *The Shadow's Edge. Australia's Northern War*. Melbourne: Melbourne University Press.

- Poynton, P. 1996. Dream lovers. Indigenous people and the inalienable right to self-determination. In *Resources, Nations and Indigenous Peoples. Case studies from Australasia, Melanesia and Southeast Asia*, edited by R. Howitt, J. Connell and P. Hirsch. Melbourne: Oxford University Press.
- Pritchard, S. 1990. Self determination: the rights of indigenous peoples under International Law. Submission to Royal Commission into Aboriginal Deaths in Custody. Sydney: National Aboriginal and Islander Legal Services Secretariat.
- Prochaska, J.O. , and C.C. Di Clemente. 1986. Towards a comprehensive model of change. In *Treating Addictive Behaviours: processes of change*, edited by W. R. Miller and N. Heather. New York: Plenum.
- Race Discrimination Commissioner. 1995. Alcohol Report. Race Discrimination, Human Rights and the Distribution of Alcohol. Canberra: Australian Government Publishing Service.
- Read, P. 1988. Darce Cassidy's Freedom Ride. *Australian Aboriginal Studies* 1988 (no. 1):45-53.
- Read, P. 1990a. *Charles Perkins: a biography*. Ringwood, Vic: Viking.
- Read, P. 1990b. Cheeky, insolent and antiwhite: the split in the Federal Council for the Advancement of Aborigines and Torres Strait Islanders - Easter 1970. *Australian Journal of Politics and History* 36 (1):93-83.
- Reid, J, ed. 1982. *Body, Land and Spirit. Health and Healing in Aboriginal Society*. 1st ed. St Lucia: Queensland University Press.
- Reid, J. 1983. *Sorcerers and Healing Spirits. Continuity and change in an Aboriginal medical system*. Canberra: Australian National University Press.
- Richards, J., C.W. Binns, D. Blaze-Temple, C. Dowling, and J. Logan. 1989. Terms and definitions for use in drug-related research in Australia. Perth: National Centre for Research into the Prevention of Drug Abuse, Curtin University.

- Richmond, R., K.G. Novak, L. Kehoe, G. Calfas, C.P. Mendelsohn, and A. Wodak. 1998. Effect of training on general practitioners' use of a brief intervention for excessive drinkers. *Australian and New Zealand Journal of Public Health* 22 (2):206-209.
- Rifkin, S.B. 1978. Politics of Barefoot Medicine (letter). *The Lancet* January 7:34.
- Rifkin, S.B. 1986. Lessons from community participation in health programmes. *Health Policy and Planning* 1 (3):240-249.
- Roche, A.M. 1996a. Increasing primary care providers' willingness to intervene in alcohol and drug-related problems: a review. *Substance Abuse* 17 (4):201-217.
- Roche, A.M. 1996b. When is a paradox no longer paradoxical: rethinking approaches to the prevention of alcohol and drug problems. *Drugs in Society* 3/96:11-14.
- Roche, A.M., and K.R. Evans. 1998. The implications of drinking patterns for primary prevention, education and screening. In *Drinking Patterns and Their Consequences*, edited by M. Grant and J. Litvak. Washington: Taylor and Francis.
- Roizen, R. 1991. The American Discovery of Alcoholism 1933-1939. PhD., University of California, Berkeley.
- Rollnick, S., and A. Bell. 1991. Brief motivational interviewing for use by the non-specialist. In *Motivational Interviewing: preparing people to change addictive behaviours*, edited by W. R. Miller and S. Rollnick. New York: Guildford Press.
- Rollnick, S., N. Heather, and A. Bell. 1992. Negotiating behaviour change in medical settings: the development of brief motivational interviewing. *Journal of Mental Health* 1:133-139.
- Room, R. 1984a. The World Health Organization and alcohol control. *British Journal of Addiction* 79:85-92.
- Room, R. 1984b. Alcohol and ethnography: a case of problem deflation? *Current Anthropology* 25 (2):169-178.
- Room, R. 1985a. Dependence and society. *British Journal of Addiction* 80:133-139.

- Room, R. 1985b. 'An intoxicated society?' Issues then and now in Australia. In *The World Alcohol Industry with special reference to Australia, New Zealand and the Pacific Islands*, edited by J. Cavanagh, F. Clairmonte and R. Room. Sydney: Transnational Corporations Research Project, University of Sydney.
- Rose, G. 1994. *The Strategy of Preventive Medicine*. Oxford: Oxford University Press.
- Rowley, C.D. 1973. *Outcasts in White Australia*. Ringwood, Vic: Penguin.
- Rowley, C.D. 1974. *The Destruction of Aboriginal Society*. Ringwood, Vic: Penguin.
- Rowse, T. 1996. *Traditions for Health. Studies in Aboriginal Reconstruction*. Canberra and Darwin: North Australia Research Unit, ANU.
- Rowse, T. nd. Perspectives on the cultures of sexuality among Central Australian Aboriginal people. Alice Springs: Menzies School of Health Research.
- Rutstein, D.D., W. Berenberg, and T.C. Chalmers. 1976. Measuring the quality of medical care: a clinical method. *New England Journal of Medicine* 294:582-588.
- Sackett, L. 1988. Resisting arrests: drinking, development and discipline in a desert context. *Social Analysis* 24 (Dec):66-77.
- Saggers, S., and D. Gray. 1991. *Aboriginal Health and Society: The traditional and contemporary Aboriginal struggle for better health*. St Lucia: University of Queensland Press.
- Saggers, S. , and D. Gray. 1998. *Dealing with Alcohol. Indigenous Usage in Australia, New Zealand and Canada*. Cambridge: Cambridge University Press.
- Sahlins, M. 1995. *How 'Natives' Think. About Captain Cook for example*. Chicago: University of Chicago Press.
- Salaspuro, M. 1994. Biological state markers of alcohol abuse. *Alcohol Health and Research World* 18 (2):131-139.
- Sansom, B. 1980. *The Camp at Wallaby Cross. Aboriginal fringe dwellers in Darwin*. Canberra: Australian Institute of Aboriginal Studies.

- Saunders, J.B., O.G. Aasland, A. Amundsen, and M. Grant. 1993. Alcohol consumption and related problems among primary health care patients: WHO collaborative project on early detection of persons with harmful alcohol consumption I. *Addiction* 88:349-362.
- Schaler, J.A. 1996. Thinking about drinking: the power of self-fulfilling prophesies. *The International Journal of Drug Policy* 7 (3):187-192.
- Seidel, G., and L. Vidal. 1997. The implications of 'medical', 'gender in development' and 'culturalist' discourses for HIV/AIDS policy in Africa. In *Anthropology of Policy. Critical perspectives on governance and power*, edited by C. Shore and S. Wright. London: Routledge.
- Senate Legal and Constitutional References Committee. 1995. Trick or Treaty? Commonwealth Power to Make and Implement Treaties. Canberra: Senate Printing Unit, Parliament House.
- Shirt, E. 1993. Eric Shirt from CAAAPU. Paper read at Very Very Very Remote Allied Health Professionals Conference, 1-5 February 1993, at Alice Springs.
- Shore, C., and S. Wright, eds. 1997a. *Anthropology of Policy. Critical Perspectives on Governance and Power*. London and New York: Routledge.
- Shore, C., and S. Wright. 1997b. Policy. A new field of anthropology. In *Anthropology of Policy. Critical perspectives on Governance and Power*, edited by C. Shore and S. Wright. London: Routledge.
- Sibthorpe, B. 1988. 'All our people are dyin". Diet and stress in an urban Aboriginal community. Ph.D., Department of Prehistory and Anthropology, Australian National University, Canberra.
- Sibthorpe, B., and B. Lear. 1994. Circumstances Surrounding Needle Use Transitions among Injection Drug Users: Implications for HIV Intervention. *International Journal of the Addictions* 29 (10):1245-1257.
- Smith, D. 1997. Goals and targets: applicability to primary health care. *Australian Journal of Primary Health - Interchange* 3 (1):92-102.
- Smith, D.E. 1993. *ATSIC's mechanisms for resource allocation: current policy and practice*. Vol. 41, *CAEPR Discussion Paper*. Canberra: Centre for Aboriginal Economic Policy Research, Australian National University.

- Sobell, L.C., M.B. Sobell, and T. Toneatto. 1992. Recovery from Alcohol Problems Without Treatment. In *Self control and the Addictive Behaviours*, edited by N. Heather, W. R. Miller and J. Greeley. New York: Maxwell Macmillan.
- Sobell, L.C., M.B. Sobell, T. Toneatto, and G.I. Leo. 1993. What Triggers the Resolution of Alcohol Problems Without Treatment? *Alcoholism: Clinical and Experimental Research* 17 (2):217-224.
- Soong, F.S. 1981. Cultural brokers in East Arnhem Land: a study of the role of the Aboriginal Health Worker. Dip.Anth., Anthropology, University of Sydney, Sydney.
- Spark, R., R. Donovan, and P. Howat. 1991. Promoting health and preventing injury in remote Aboriginal communities. *Health Promotion Journal of Australia* 1 (2):10-16.
- Speare, R., and K.A. Kelly. 1991. *Health Needs of Aboriginals and Islanders in the Townsville Region. The role of Black Medical Services*. Townsville: Anton Breinl Centre for Tropical Health and Medicine, James Cook University.
- Spencer, D.J. 1988. Transitional alcoholism - the Australian Aboriginal model. *Technical Information Bulletin, Drug Issues Affecting Aboriginal Australians* 79 (AGPS):15-21.
- Stall, R. 1983. An examination of spontaneous remission from problem drinking in the Bluegrass region of Kentucky. *Journal of Drug Issues* 13 (2):191-206.
- Stampar, A. 1966. Presidential Address. First World Health Assembly, Geneva, June 25 1948. In *Serving the Cause of Public Health: Selected papers of Andrija Stampar*, edited by M. D. Grmek. Zagreb: Andrija Stampar School of Public Health, University of Zagreb.
- Stibler, H. 1991. Carbohydrate-deficient transferrin in serum: a new marker of potentially harmful alcohol consumption reviewed. *Clinical Chemistry* 37 (12):2029-2037.
- Stockwell, T., E. Single, D. Hawks, and J. Rehm. 1997. Sharpening the focus of alcohol policy from aggregate consumption to harm and risk reduction. *Addiction Research* 5 (1):1-9.
- Sumner, M., L. Sumner, and D. Kilgariff. 1992. Report Healing our Spirit Worldwide Conference' Edmonton, Alberta, Canada July 7th-11th, 1992. Adelaide: Aboriginal Sobriety Group of SA. Inc.

- Sykes, B. 1971. Parallels. *Identity* October:31-32.
- Tarimo, E., and E.G. Webster. 1997. *Primary Health Care Concepts and Challenges in a Changing World. Alma-Ata Revisited*, WHO/ARA/CC/97.1. Geneva: World Health Organisation.
- Tatz, C. 1972. The Politics of Aboriginal Health. *Politics (suppl)* VII (2):3-23.
- Territory Health Services. 1996. Aboriginal Health Policy. Darwin: Territory Health Services.
- Tharawal Aboriginal Corporation. 1994. Aboriginal Health in South West Sydney. Report of the Tharawal Aboriginal Family Environment Health Study. Campbelltown: Tharawal Aboriginal Corporation.
- Thomson, N. 1984. Australian Aboriginal health and health care. *Social Science and Medicine* 18:939-948.
- Topper, M.D. 1981. The Drinker's Story: an Important But Often Forgotten Source of Data. *Journal of Studies on Alcohol suppl no.9*:73-85.
- Torres, M.I., R.P. Mattick, R. Chen, and A. Baillie. 1995. *Clients of Treatment Service Agencies. March 1995. Census Findings*. Canberra: Commonwealth Department of Human Services and Health.
- Torzillo, P., and C. Kerr. 1991. Contemporary issues in Aboriginal public health. In *The Health of Aboriginal Australia*, edited by J. Reid and P. Trompf. Sydney: Harcourt Brace Jovanovich.
- Tregenza, J., and K Abbott. 1995. Rhetoric and Reality. Perceptions of the roles of Aboriginal Health Workers in Central Australia. Alice Springs: Central Australian Aboriginal Congress.
- Tsey, K. 1996. Aboriginal health workers: agents of change? *Australian and New Zealand Journal of Public Health* 20 (3):227-229.
- Tucker, J.A., R.E. Vichinich, and J.A. Gladsjo. 1994. Environmental Events Surrounding Natural Recovery from Alcohol-Related Problems. *Journal of Studies on Alcohol* 55 (4):401-411.
- United Church in North Australia. 1974. Free to Decide. The United Church in North Australia Commission of Enquiry, Arnhem Land. Darwin: United Church.
- van Meijl, T. 1993. A Maori perspective on health and its politicisation. *Medical Anthropology* 15:283-297.

- Viner, I. 1978. Hansard Report. Canberra: House of Representatives.
- Vogel, V.J. 1990. *American Indian Medicine, The Civilization of the American Indian Series*. Norman: University of Oklahoma.
- Volk, R.J., J.R. Steinbauer, S.B. Cantor, and C.E. Holzer. 1997. The Alcohol Use Disorders Identification Test (AUDIT) as a screen for at-risk drinking in primary care patients of different racial/ethnic backgrounds. *Addiction* 92 (2):197-206.
- Wallace, P., S. Cutler, and A. Haines. 1988. Randomised controlled trial of general practitioner intervention in patients with excessive alcohol consumption. *British Medical Journal* 297 (10 September):71-78.
- Walsh, D.C., and R.W. Hingson. 1987. Epidemiology and alcohol policy. In *Epidemiology and health policy*, edited by S. Levine and A. M. Lilienfeld. New York: Tavistock.
- Waterford, J. 1979. Discriminating diplomacy. *Identity* 3 (11):15-16.
- Waterford, J. 1982. The Aboriginal Medical Services - a uniquely Australian phenomenon. *Aboriginal Health Project Information Bulletin* 2 (August):16-20.
- Weaver, S.M. 1993. Self-determination, national pressure groups, and Australian Aborigines: the National Aboriginal Conference 1983-1985. In *Ethnicity and Aboriginality. Case studies in ethnonationalism*, edited by M. D. Levin. Toronto: University of Toronto Press.
- Weeks, C., and M. Bollen. 1996. Divisions of General Practice - the new kids on the public health block? *In Touch* April:8-9.
- Wells, E. 1982. *Reward and Punishment in Arnhem Land*. Canberra: Australian Institute of Aboriginal Studies.
- Westermeyer, J. 1981. Research on treatment of drinking problems. Importance of cultural factors. *Journal of Studies on Addiction Supp* 9:44-59.
- Williams, S., J. Weinman, J. Dale, and S. Newman. 1995. Patient expectations: What do primary care patients want from the GP and how far does meeting expectations affect patient satisfaction? *Family Practice* 12 (2):193-201.

Williams, S.J., and M. Calnan. 1991. Key Determinants of Consumer Satisfaction with General Practice. *Family Practice* 8 (3):237-242.

Willis, E. 1984. Has the primary health worker program been successfully exported to the Northern Territory? *Aboriginal Health Project Information Bulletin* 6 (August):13-18.

Willis, E. 1985. Servant of Two Masters. A study of an Aboriginal Health Worker literacy program in the southern region of the Northern Territory. Master of Education, Education, University of New England, Armidale.

Willis, E. 1997. Theorising interactions amongst Aboriginal health workers and remote area nurses: from Stonequist to Foucault? In *Nursing Matters*, edited by H. Kelleher and F. McInery. Melbourne: Pearson Professional.

Wilmsen, E.N., and P. McAllister, eds. 1996. *The Politics of Difference. Ethnic premises in a world of power*. Chicago: University of Chicago Press.

Wilson, W.T. 1986. An analysis of federal government action on the provision of effective preventive, treatment, and rehabilitative services for Aboriginal alcohol abusers. Canberra.

Winch, J. 1978. Alternative Health Care. *Identity* October:8-9.

Wood, C.S. 1990. Maori Community Health Workers: a mixed reception in New Zealand. In *Anthropology and Primary Health Care*, edited by J. Coreil and J. D. Mull. Boulder: Westview Press.

Working Panel on Aboriginals, Torres Strait Islanders and HIV/AIDS. 1989. Report of the Working Panel on Aboriginals, Torres Strait Islanders and HIV/AIDS. Canberra: Commonwealth Department of Health.

Wroe, Y. 1995. Indigenous alcohol and other drug conference. *Connexions* 15 (1):10.

Wutzke, S.E., M.K. Gomei, and R.J. Donovan. 1998. Enhancing the delivery of brief interventions for hazardous alcohol use in the general practice setting: a role for both general practitioners and medical receptionists. *Health Promotion Journal of Australia* 8 (2):105-108.

Zinberg, N. 1984. *Drug, Set and Setting: the basis for controlled intoxicant use*. New Haven: Yale University Press.