

SOCIAL DETERMINANTS OF DRUG USE

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EXECUTIVE SUMMARY

Introduction

- Despite significant expenditure on drug prevention, problematic drug use has increased and new drug-related problems have emerged. For example, while 3 per cent of people born between 1940 and 1994 had used cannabis by age 21, 59 per cent of people born between 1975 and 1979 had done so. Further, in the past decade, the use of ecstasy and related drugs increased from a rare phenomenon to a situation where, in 2001, 20 per cent of 20–24 year olds reported that they had ever used ecstasy.
- Research indicates negative trends in other psychosocial problems. For example, suicide rates among 15–24 year olds have increased from 6 per 100,000 in 1921–25 to 16 per 100,000 in 1996–98. This common trend, it is argued, reflects some shared aetiology between drug-use behaviours, and other negative outcomes such as delinquency/crime and mental health problems.
- A variety of factors contribute to drug use and other problem outcomes, both individual and environmental. While drug prevention and treatment have traditionally focused on changing individual behaviours, such efforts can have only limited impact when changes are not made to the environment, that is, to the social determinants of drug use. These include the social and cultural environment, the economic environment and the physical environment.
- Western society is undergoing rapid change (for example, more parents working, longer working hours, changes to family structure, extension of the period of adolescence) and there are concerns that societal institutions (for example, childcare and education) are not coping sufficiently with this change. This situation may be contributing to the negative trends in drug use and other psychosocial problems.
- This report focuses on social determinants of drug use, and structural interventions to address those social determinants. It draws upon recent research on the social epidemiology of health. The report incorporates a developmental perspective, noting that the influence of the environment is important and cumulative across the life course of individuals.
- Given the broad scope of this report, the authors adopted a methodological approach of integrating, as much as possible, the findings of existing reviews of the literature in each area addressed. As such, the report cannot examine any issue in great depth. Rather, the aim is to provide the reader with a broad understanding of the complex developmental and social issues associated with the development and exacerbation of drug-use problems.

Human development and drug use

- Human development is a complex interplay of individual and environmental factors across the life course. Key concepts in understanding healthy human development include:
 - Stress — prolonged stress is detrimental to health and well-being
 - Essential to positive/healthy human development and the prevention of a range of problems are:
 - resilience — resilient people can have positive outcomes even in adverse conditions
 - self-regulation
 - human relationships and attachment.
 - Parents usually play a crucial role in development.
 - Each stage of life has a set of developmental tasks, the achievement of which is essential for healthy development. The transition from one life stage to the next involves a period of adjustment during which support is needed and the individual is more receptive to assistance than at other times.
- Most attention in the research literature has focused on the early years and adolescence, however researchers note that the middle years of childhood, the transition to adulthood and adulthood itself involve important developmental tasks and issues.
- An increased awareness and understanding of how the early years of development affect learning, mental health, behaviour and physical health throughout life are evident in the literature. The early years constitute a period during which there is substantial brain development — neurons are connected, pruned or sculpted. Features of the early years of development include:
 - Critical or sensitive periods for brain development. The development of children who do not receive the nutrition and stimulation necessary for development in the early months and years will be significantly impeded.
 - During this time significant and repeated stressful events (for example, child abuse) can affect neural development and the development of other body systems (for example, the immune system). This system response to stress is called the ‘allostatic load’ and can impact upon the stress response for life. Hence, the association between child abuse and later substance abuse.
 - Investments in early child development have been found to have cost-effective outcomes across multiple domains for the individual and broader society.
- While the early years of life have attracted increased attention in the past decade, adolescence and the transition to adulthood remain important periods of development. These developmental periods have changed in the last century. For example, the period of adolescence has been extended (resulting in a longer period of dependence upon parents and few responsibilities); adolescents spend less time interacting with adults in the normal course of life and more time exclusively with

peers; there is greater societal emphasis on tertiary education for career prospects and less certainty about the future.

- Drug-use behaviours are the result of interaction between the developmental processes described above and environmental factors. Different risk factors are salient at different times of life and earlier factors influence the development of further risk of drug abuse. Examples of risk factors for the development of drug abuse across the life course include:
 - conception: genetic predisposition
 - gestation: drug use in pregnancy
 - neonatal and infancy: difficult temperament
 - preschool: early behavioural and emotional disturbances (for example, oppositional defiant disorder, depression)
 - primary school: inability to self-regulate emotions and behaviour
 - high school: exposure to drugs and drug-using social contexts.

Factors that exacerbate these risk factors include cognitive limitations, poor parenting and low family socio-economic status.

- Human development is shaped by a number of institutions throughout life. Perhaps the most important of these is the family. Others include the childcare system, the education system and the legal system. The multiple ways in which these systems can affect health and drug-use behaviours is discussed.
- The chapter concludes with recommendations for:
 - systems/infrastructure to support healthy child, youth and adult development throughout the life course (for example, support for families in raising children, structures for youth development, and support for adolescents and adults in achieving success in education and employment)
 - ‘safety nets’ or early interventions for those who are beginning a potentially negative pathway (for example, the provision of options for youth who are not doing well at school)
 - assistance during challenging transitions, particularly for those who are not doing well (for example, assistance for people coming out of prison and for drug-dependent pregnant women).

Social and cultural environment

This chapter is concerned with cultural and social–structural factors that contribute to drug use.

- ‘Culture’ refers to norms, beliefs, values and meanings.
- The term ‘social structure’ can be used in a variety of ways, each of which is useful. These include:
 - the roles, relationships and domination associated with categories of, for example, gender, race and class
 - the social, economic and cultural characteristics of a society
 - societal systems and institutions (for example, education system, welfare policies, laws).

The first two conceptualisations are discussed in this chapter. Societal systems and institutions are discussed throughout the report. Culture and social structures are inextricably linked, but discussed separately for explanatory purposes.

Culture

In this chapter, culture is divided into drug-specific and non-drug-specific cultural influences on drug use. Drug-specific cultural influences are norms regarding acceptable patterns of drug use while non-specific cultural influences refer to those aspects of western culture that influence general attitudes and norms. Examples include individualism, neo-liberalism and secularism. The broader culture can influence:

- individual risk factors for drug use such as social alienation and social support
- environmental risk factors such as social cohesion and social exclusion
- societal systems and institutions.

For example, social values around individualism can (a) contribute to feelings of alienation and connectedness; (b) reduce social cohesion; and (c) influence the policies that support (or fail to support) families and children (for example, ‘family-friendly’ workplace policies, provision of childcare, welfare policies). Another example is the impact of secularism on Western culture, which results in a lack of shared meaning and values. In this chapter the authors contend that, while there are some positive aspects to Western culture, other features have been detrimental to youth development and contributed negative outcomes, such as youth suicide and drug use.

Drug-specific cultural influences vary with factors such as drug type, setting, group characteristics and historical time. For example, smoking has been fashionable and acceptable in earlier times, but is now neither fashionable nor acceptable among the general population. Drinking to high levels of intoxication can be acceptable and even encouraged among some subgroups in some settings (for example, the pub on a Friday night), but unacceptable among others. Drug-specific norms and values are shaped by a range of factors, such as the mass media (including entertainment, news and marketing), trends in youth culture (for example, ‘heroin chic’) and laws and their enforcement.

Attempting to change cultural trends, or to address the negative impacts of cultural trends, can be difficult. Ongoing monitoring and research into the negative impacts of cultural factors, and addressing these negative impacts, are warranted. Possible action includes governments and the media placing greater emphasis on population health than on economic growth, and community leaders promoting cultural values that contribute to population health, such as caring for those in need.

Social categories

Social categories such as class, gender and race can influence access to resources, exposure to marginalisation, roles and expectations. As a result, health outcomes, drug use and drug outcomes are influenced by social category. For example, people from low socio-economic classes have poorer health and are more likely to use tobacco, to drink alcohol in a high-risk manner and to use illicit drugs.

Drug-dependent people are particularly likely to be unemployed and to experience marginalisation, both of which can exacerbate their problems and prevent seeking or benefiting from treatment. This report recommends that social policies:

- address existing social-group inequalities in drug problems
- address marginalisation and social exclusion in society as a preventive measure
- address marginalisation and social exclusion among drug-dependent people to facilitate achieving and maintaining reductions in drug use and other problems
- ensure that policies do not exacerbate existing disadvantages experienced by social groups by considering how they impact upon the psychosocial and material conditions faced by disadvantaged people.

Social environment at the community level

The last decade has generated substantial interest in the concepts of social capital, social cohesion, collective efficacy and social exclusion. While these concepts suffer from poor conceptualisation and measurement, they appear to be highly correlated and generally refer to a notion of community resilience. While evidence is mixed about the importance of such concepts for health and social outcomes, such as drug use and crime, research on risk factors for drug abuse suggests that the availability of social support/networks, social inclusion, social activity, shared (pro-social) norms, feelings of belonging could be protective against drug-abuse problems in the community. The report recommends that:

- evidence-based community-building programs be a priority for disadvantaged communities
- policies and programs that negatively affect community resilience be changed.

Social environment at the global level

Globalisation refers to the process by which activities, ideas and cultures influence one another on a global scale. In the last two decades the rate and extent of globalisation have increased, largely as the result of advances in technology. The impacts of globalisation on societies can be both positive and negative, and vary between countries. For example, globalisation can contribute to employment in Third World nations, while at the same time increasing pressure on workers in wealthier nations, as they try to compete with cheaper labour markets. There has been recent concern regarding the impact of globalisation on drug markets, drug and social policies and drug use. For example, globalisation is accused of contributing to identity confusion and a sense of powerlessness among young people, which can result in problems such as depression and drug abuse. Other global influences appear to have positive effects on development; for example, the efforts of organisations such as the United Nations in promoting the rights of children.

Socio-economic environment

This chapter reviews recent research examining the impact of individual, family and community socio-economic environments on health and drug-use outcomes. The literature indicates that:

1. Low socio-economic status and income inequality are often associated with poor health and well-being. Models describing these relationships are complex, but the impact of the socio-economic environment on health appears to be partly mediated by the impact of socio-economic factors on drug and alcohol use.
2. Low socio-economic status is not evenly distributed throughout the community. It tends to be geographically concentrated and experienced disproportionately by particular demographic groups, such as Aboriginal and Torres Strait Islander peoples and sole parents. Those born into low socio-economic status

environments are unlikely to increase their level of socio-economic status. Accordingly, problems associated with poor socio-economic environments are likely to be concentrated among these disadvantaged groups/communities and to be transmitted between generations.

3. Evidence suggests that the relationship between low socio-economic status and drug use is bi-directional, where low socio-economic status can cause increased drug use and, to a lesser extent, drug use can serve to lower one's socio-economic status. Hence, a self-perpetuating cycle can exist between low socio-economic status and drug use, which is likely to embed itself within disadvantaged sectors of the community.
4. Low socio-economic status can affect drug use and related harms in a number of ways. For instance, low socio-economic status can create chronic stress resulting in negative impacts upon an individual's mental health and immune responses; as well as reduced access to resources such as mental health services, education, recreation and social support. Children raised in low socio-economic status families (particularly working poor who work long hours for little pay) experience less supervision and care, which can be conducive to the development of drug-use problems. Low socio-economic status communities are often characterised by high unemployment, drug use and drug availability, crime etc, which provide a cultural environment that is conducive to problem drug use.
5. The research literature contains a number of implications for ways to address the impact of the socio-economic environment on drug use and drug outcomes:
 - a. In order to alleviate the detrimental effects of poverty and disadvantage, interventions need to be targeted at different points along the causal chain.
 - b. Poverty and disadvantage should be addressed via employment programs, taxation policies and education policies.
 - c. In addition to universal programs, targeted programs are needed for disadvantaged groups and communities to address existing inequities in drug problems and to reduce intergenerational transmission of drug problems.
 - d. Poverty and disadvantage need to be addressed at the individual, family, community and national level.

Physical environment

Aspects of the physical environment have been demonstrated to affect physical and mental health, and the social environment. Impacts described in the research literature are summarised below.

Aspect of the physical environment	Impacts
<i>Housing</i>	
Housing quality	Self-identity Despondency Depression
Overcrowding	Depression Noise, which impacts: <ul style="list-style-type: none"> • children's academic attainment • stress

Aspect of the physical environment	Impacts
Cost Availability	Exacerbates poverty Homelessness Insecurity Mobility, which impacts children's academic achievement and socialisation
<i>Spatial patterns</i> Concentration of public housing	Concentration of disadvantage Crime rates Drug markets Identity and self-esteem Social norms regarding education, employment, crime, drug use
Suburban sprawl	Social networks Civic networks
Geographic isolation — rural and remote communities	Access to resources and opportunities, which impact: <ul style="list-style-type: none"> • boredom • employment
<i>Community physical disorder</i>	Community perceived as unsafe and unappealing → People stay indoors → Reduced social interactions and networks
<i>Inadequate public transport</i> Increased car dependency and traffic flow	Areas perceived as less safe and friendly → Less walking → Less public interaction Increased stress Constraints on child development: <ul style="list-style-type: none"> • less exploration of the environment • reduced social contacts Effect on drink-driving and drug-driving
Exacerbation of impacts of low socio-economic status	Reduced access to: <ul style="list-style-type: none"> • job interviews and employment opportunities • social networks → loneliness, depression • recreation → boredom, motivation
<i>Public spaces</i> Lack of public spaces in which young people can socialise in the presence of adults	Increased exposure to drug markets and antisocial youth Decreased informal social controls from adults and adult role models

The impacts of the physical environment listed above may then act as risk factors for drug abuse. While there is mixed evidence concerning the impact of housing quality on lung cancer rates, little specific research has focused on the impacts of the physical environment on drug-use behaviours and outcomes. However, research into aspects of

particular environments (settings) and their effect on particular drug-use behaviours or outcomes has demonstrated that:

- Physical features of licensed premises can affect alcohol-related violence.
- The provision of public transport can reduce alcohol-related violence and drink-driving.
- Physical features of a local environment can have an influence on unsafe injecting practices.
- Accommodation options can affect access to services and the well-being of heroin users.
- Policies and laws that allow smoking in enclosed spaces, particularly without proper ventilation, can contribute to smoking-related diseases due to passive smoking.

In sum, resources such as housing, urban planning and transport are likely to affect the environment in a manner that promotes or prevents drug-use problems.

Universal or targeted programs

Drug prevention interventions can be ‘universal’ or ‘population’ approaches (targeting the whole population), targeted approaches (targeting a high-risk group) or indicated approaches (targeting those who are already experiencing a problem). An argument for universal approaches suggests that there are generally more low-risk individuals in the population than high-risk individuals and a large number of low-risk individuals can contribute more problem cases than a small number of high-risk individuals.

Consequently, universal interventions can affect more people and have a greater population impact. The benefits cited for targeted programs are that they can be more cost-effective and are necessary for addressing existing inequities.

This report recommends that a mix of universal and targeted approaches be used to address drug-related problems. Two disadvantaged groups in Australia, whose children are disproportionately represented in the criminal justice system and experience a higher rate of drug-related problems than the general community, are discussed: sole-parent families and Aboriginal and Torres Strait Islander peoples.

Sole-parent families

An increasing proportion of Australian children are living in sole-parent families: the rate increased from 12 per cent in 1976 to 25 per cent in 2001. By adolescence, half of the population has lived in a sole-parent family at some time in their lives. Children of sole-parent families have been found to develop up to five times the rate of emotional, behavioural, social and academic problems relative to other children. Specifically, children of sole-parent families are more likely to smoke, drink heavily and to use illicit drugs.

A multitude of reasons have been found or hypothesised to explain these results. These include:

- factors present prior to the separation:
 - socio-economic disadvantage
 - elevated rates of adverse life events
 - higher levels of inter-parental conflict
- the stress associated with separation or divorce
- post-separation conditions:

- socio-economic disadvantage
- the amount of time that parents can engage with their child in play or school-related activities
- more reliance on friends and peer groups who use substances
- continuing conflict between parents
- stress of moving house and repartnering
- less effective coping skills in divorced children
- impaired parental monitoring and parenting practices. Divorced parents also use more drugs and alcohol than do never-divorced parents.

The low socio-economic status of sole-parent families is of particular concern. While different measures of poverty result in different rates of poverty among sole-parent families, the over-representation of sole-parent families in poverty statistics is constant:

- The Australian Bureau of Statistics reported that, in 2001, over 350,000 families with children aged less than 15 years had no employed resident parent. Almost two-thirds (64 per cent) of these families were one-parent families.
- The Luxemburg Income Study reported that Australian lone-parent households have a poverty rate of 56 per cent compared with 8 per cent for couple families.

Clearly economic hardship among sole-parent families is a primary issue that needs to be addressed. Also, there is a clear need for practical support in raising children, for example, via childcare services, mentor programs and youth development programs.

Aboriginal and Torres Strait Islander peoples

The health, well-being and drug-use patterns of Aboriginal and Torres Strait Islander peoples are significantly worse than for the rest of the Australian population. A multitude of reasons have been found or hypothesised to explain this situation. While the experiences of Aboriginal and Torres Strait Islander communities are not the same, many experienced brutality and trauma from the European usurpation of their lands. This was followed by successive policies of 'protection' and 'assimilation', one objective of which was to reshape Aboriginal and Torres Strait Islander peoples societies in the image of the dominant society, with all the undermining of Aboriginal and Torres Strait Islander peoples cultural practices, languages and so on that this entailed. These experiences weakened communities, the authority of elders, and family strength, as well as contributing to stress and trauma, loss of culture and loss of parenting skills. Policies that deprived Aboriginal and Torres Strait Islander peoples of status, power or self-determination contributed to feelings of inferiority, powerlessness and hopelessness. European settlers introduced tobacco and alcohol to Aboriginal and Torres Strait Islander peoples as a form of payment and to procure sexual favours. Then prohibitions were introduced, so the status of alcohol increased to be regarded as a race/class privilege. The experience of Aboriginal and Torres Strait Islander peoples resulted in loss of positive role models and loss of social capital. This in turn has resulted in:

- poorer educational attainment
- unemployment, which contributes to welfare dependency, apathy, boredom, loss of self-esteem and economic disadvantage
- physical and mental health problems, including self-harm and suicide
- alcohol and other drug use, crime rates and violence.

All of the above contribute to many Aboriginal and Torres Strait Islander peoples feeling hopeless, angry, traumatised and ashamed, and being stigmatised (victim blaming) and marginalised (socially excluded). These outcomes further contribute to their alcohol and other drug problems.

Other contributors to alcohol and other drug problems include:

- living in remote communities that lack access to resources
- the series of failed interventions that have characterised previous attempts to address the problems experienced by Aboriginal and Torres Strait Islander peoples (for example, welfare dependency, drug/alcohol interventions). These interventions have been inadequate and have not addressed the fundamental causes of problems. These failures have further contributed to a sense of hopelessness among Aboriginal and Torres Strait Islander peoples and the wider community.

In sum, alcohol and other drug-use problems among Aboriginal peoples are the result of a long history of social problems, which cannot be fixed by a simple intervention.

Recommendations for addressing the existing situation include:

- Build strength/resilience (feelings of hope, family strength, community capital) in addition to addressing specific problems such as drug use, suicide, crime, unemployment and domestic violence.
- Publicise and promote successes/strengths of Aboriginal and Torres Strait Islander peoples rather than focus on problems — to raise sense of hope among Aboriginal and Torres Strait Islander peoples as well as in the broader community.
- Facilitate self-help and self-determination, without expecting communities to do it alone.
- Employ a whole-of-government approach so that resources can be used efficiently and effectively.
- Be realistic — change will take time.

Conclusions and Recommendations

Understand the complexity of the development of drug-use behaviours

The complex nature of the development of drug-use behaviours and problems needs to be appreciated. This means, for example:

- Understanding the development of problems across the life course rather than focusing only on the period of initiation of drug use.
- Understanding that there are shared risk and protective factors for drug-use behaviours and other problem behaviours, so treating drug use in isolation can be inefficient. Drug prevention initiatives need to address shared determinants with crime prevention, suicide prevention, bullying prevention and so on.
- There are multiple risk factors for drug use across multiple domains; failure to address the spectrum of contributors to drug-use problems will result in limited benefit.
- Any single intervention, single sector or single worker can have only a limited impact on drug-use problems. No person, agency or sector by itself can ‘fix’ an individual or a community. Comprehensive and sustained action is needed for effective prevention and treatment.

Investments to support human development across the life course

Investment in development across the life course is needed, as well as specific problem prevention strategies. Such investments need to incorporate:

- structures for child and youth development. For example, there are currently few programs provided for adolescents outside school hours; ‘full-service schools’ which have been developed in the United States of America provide one model for extending existing infrastructure towards this end
- early interventions and safety nets across the life course for those who begin problematic trajectories (for example, diversion programs for drug offenders). Transition periods, in particular, might require greater assistance. For example, the transitions from high school to the workforce and from prison to the community require support and the provision of opportunities to facilitate successful transition
- greater assistance (rather than marginalisation and punishment) for those who are not managing; for example, commitment to rehabilitation and support for people in the juvenile and adult prison system.

Investment in child and youth development has been shown to be cost-effective.

Holistic approach

Holistic approaches to individuals and across systems are needed:

- Whole-of-government systems can provide coordinated services, more cost-effective planning and harm prevention. Examples of mechanisms for achieving this include full-service schools (as developed in the United States of America) and Community Drug Action Teams.
- For drug-dependent people, a holistic approach to service provision is necessary to address the multiple health, family, social, socio-economic and other problems they experience. The broader service system also needs to be prepared to assist drug-dependent people, who tend to experience marginalisation and stigmatisation from mainstream service providers.
- Focus on building the resilience of individuals, families and communities rather than just preventing isolated problems.

Cultural shift

A cultural shift from a society dominated by individualism and economism to a more caring and inclusive society is needed — that is, a shift in focus from measuring progress in terms of economic growth to monitoring the health and well-being of the population.

- This requires leadership from politicians, academics and others.
- It can be promoted by schools (for example, programs such as ‘Roots of empathy’, school climate) and by community-building programs.

Inequities in drug problems

Existing inequalities in the distribution of drug problems must be addressed. This means:

- addressing each level of the causal chain from the causes of disadvantage (for example, low socio-economic status) to the mediators of disadvantage (for example, lower access to resources) to the impacts of disadvantage (for example, drug dependence)

- ensuring policies do not exacerbate disadvantage. Mechanisms for achieving this include health impact assessments, reviews of existing policies and monitoring of new policies
- affirmative action for disadvantaged groups such as sole-parent families and Aboriginal and Torres Strait Islander peoples.

Monitoring

- Trends in child, youth and adult drug use and related problems as well as social factors that contribute to these outcomes need to be monitored to identify problems as they arise.
- Activities and outcomes relating to child and youth well-being, family functioning and community resilience need to be monitored and policies and programs need to be adjusted in light of the information collected.

There are significant barriers to change. For example, it is easier and less costly in the short term to conduct interventions and research at the individual level than at the community, state and national levels. However, the environment is a powerful shaper of behaviour and health, and government and other social organisations fulfil an essential role in shaping that environment.