

CHAPTER 3: CULTURE AND SOCIAL STRUCTURES

Introduction

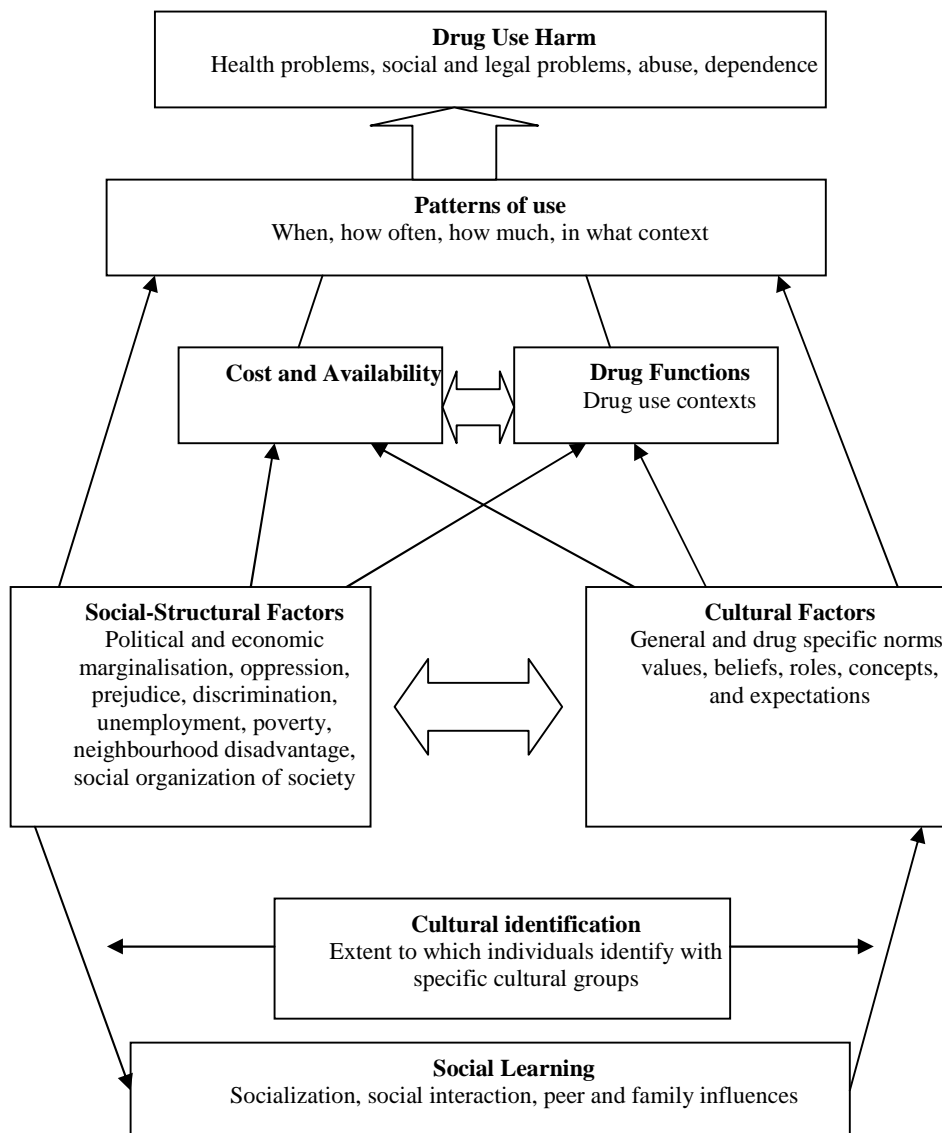
In this chapter, we discuss the influences of culture and social structures on drug use. While the term ‘culture’ is generally understood to denote norms, beliefs, values and meanings, there are multiple definitions of the term ‘social structure’.^{1 2} Further, as discussed by Eckersley, the concepts of culture and social structure are considered by some to be separate, but by others to be interconnected. Based on the various definitions used in the research literature, we have derived the following meanings for social structure:

1. the roles, relationships and domination associated with societal categories such as gender, race and class
2. the social, economic and cultural characteristics of a society
3. societal systems and institutions such as the education system and welfare policies.

No single definition of social structure encapsulates every connotation of the term as used in the literature, and the definitions above are open to a range of interpretations.

Cultural environment and social structures can influence drug-use behaviours through a number of mechanisms. A model that satisfactorily depicted all of these mechanisms and their interrelationships was not found; however, Durrant and Thakker’s model included a number of relevant factors and was found to be useful (**Figure 1**).³ In this model, patterns of drug use are directly influenced by social structural factors, cultural factors, drug availability and drug functions. Each of these factors is interconnected and influences or mediates between other factors. Social structural factors and cultural factors are themselves influenced by cultural identification and social learning (as per social learning theory).

Figure 1: An integrated model of the role of cultural factors in drug use



Source: Durrant R, Thakker, J, 2003, p. 187³

One element not included in Durrant and Thakker's model is how culture can influence policies and programs, which then directly or indirectly influence drug use. For example, Phipps has described how cultural attitudes concerning who is responsible for raising children can influence child and family policies, which then impinge upon child and adolescent outcomes (Chapter 1).⁴ Lawrence, Bammer and Chapman described how community attitudes towards drugs influenced efforts to trial prescribed heroin as a treatment option.⁵ Durrant and Thakker's model is useful, however, for illustrating the inter-relationship of cultural factors and social-structural factors, for highlighting the importance of cultural identification and social learning, and for noting the role of drug cost, availability, functions and contexts.

This chapter includes a discussion of the following cultural and social-structural influences on drug use:

- cultural influences that are specific to drug use and cultural influences that affect a range of behaviours
- social categories (class, gender and race) and the impacts of social position, marginalisation and labelling
- characteristics of society at the local community and global levels.

Cultural Factors

Cultural influences can be divided into drug-specific cultural influences that only (or primarily) influence drug-use behaviours (for example, disapproval of illicit drug use) and broader (Western) cultural influences (for example, individualism) that can have indirect influences on drug use and other behaviours (for example, antisocial behaviour). These two aspects of culture are discussed below.

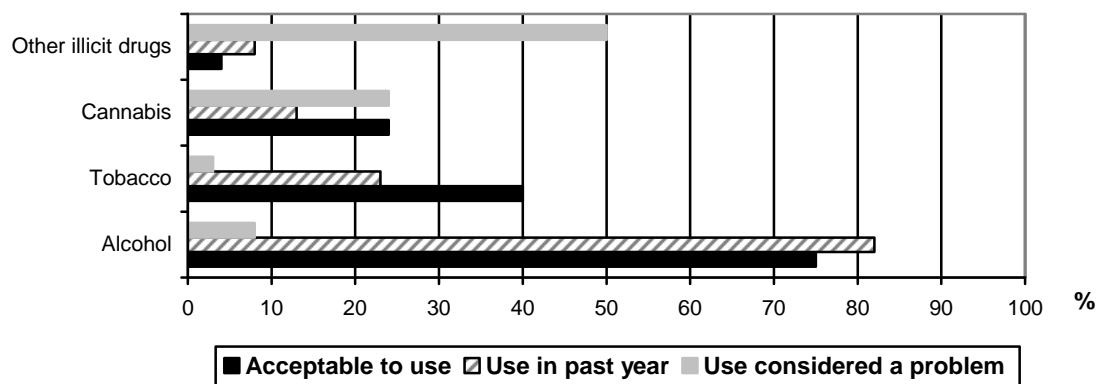
Drug-specific cultural influences

Norms regarding acceptable patterns of drug use vary with factors such as the type of drug (for example, tobacco, alcohol, cannabis or heroin), the historical period, the setting (the location, occasion and the presence of others) and group affiliation (for example, with gender, ethnic, age and social groups). These factors are briefly discussed below together with consideration of how such influences might be modified to minimise drug harms.

Drug type

Attitudes towards drug use vary with the drug type. The attitudes of Australians aged 14 years and over regarding the acceptability of use of specific drugs and drug laws (legalisation, penalties for sale and supply) were assessed by the National Drug Strategy household survey in 2001.⁶ The acceptability of drug use varied, such that the use of illicit drugs (cannabis and other illicit drugs) was less acceptable than the use of legal drugs (alcohol and tobacco) (Figure 2). Variation within these categories tended to reflect the population prevalence of use. However, the relationship between use and acceptability of use was not consistent. More respondents were likely to think smoking tobacco or cannabis was acceptable than actually used tobacco or cannabis. The converse was true in relation to alcohol and illicit drugs other than cannabis. The attitudes of the general public towards use of specific drugs appear to be influenced by factors other than their own use and the legality of the drug.

Figure 2: Attitudes to use of particular drugs and use of particular drugs in the past year



Source: National Drug Strategy Household Survey, 2001 ⁶

The acceptability of use was negatively related to the perceptions of which drugs are causing problems, and these perceptions appeared to be influenced by the drugs' legal status (Figure 2). The drug that most people 'first thought of' as being associated with a drug 'problem' was heroin (50 per cent), followed by cannabis (24 per cent). Alcohol (8 per cent) and tobacco (3 per cent) were least considered to be a problem, despite their being associated with the most harm and drug-related deaths. ⁷ Thus, attitudes towards the use of particular drugs vary with factors such as drug laws, prevalence rates of use, and perceptions of harm.

Historical period

Cultural influences on drug use have changed over time. As discussed by Parker, the use of cannabis, which was regarded as deviant 40 years ago, is now so prevalent that its use has become more normalised and socially acceptable, at least among young people. ⁸ The 1960s began a period of enormous cultural change together with the development of anti-establishment youth cultures which included hippies smoking cannabis and using LSD,^a rock-music cultures characterised by 'sex, drugs and rock'n'roll', punk rockers using heroin and so on. The use of ecstasy and related drugs was almost unheard of 20 years ago, but is now increasing and the user group is broadening, as a result of increased availability and the emergence of the dance music and club scene. ⁹ Riley and Hayward described how this drug-use trend emerged in the context of more general cultural trends 'related to a "time out" culture of hedonistic values that reflects the individualistic and risk-oriented society of western late-capitalism' (p. 260). ⁹

Pampel described how tobacco use changes over time as its status in the population changes. ¹⁰ When tobacco is first introduced into a country, new adopters (who tend to be in the wealthier section of society) start smoking. Tobacco becomes a status symbol as smoking becomes fashionable and then the general masses start smoking. The wealthier elite start to become concerned with health, fitness and the harms of smoking, and want to separate themselves from other groups by their rejection of smoking and other unhealthy lifestyles. They have the resources to do so, so smoking rates fall among the wealthier while they remain high among the less wealthy, who are less able to quit. ¹¹

^a Lysergic acid diethylamide, a hallucinogen.

These examples highlight how cultural influences on the use of specific drugs change with the historical period of concern.

Setting

Zinberg postulated that three sets of factors, namely ‘drug, set and setting’, need to be taken into account in explaining the patterns and consequences of drug use.¹² According to this framework, ‘drug’ refers to the pharmacological properties of a drug, ‘set’ refers to the characteristics of the person using the drug, and ‘setting’ refers to aspects of the social and physical environment in which the drug is consumed.

A number of researchers have argued for greater attention to setting in understanding drug-use behaviour and addressing drug problems.¹³⁻¹⁶ For example, Rhodes and colleagues described situational factors that influenced drug-injecting behaviours in a Russian city. Such factors included fear of police detainment affecting willingness to carry injecting equipment, mistrust between drug users encouraging people to inject alone, and a lack of injecting equipment outlets for obtaining clean needles and syringes.¹⁶

As part of a review of the role of police in managing alcohol-related problems, Spooner and McPherson summarised research on risk factors relating to the design and management of licensed premises that had been found to contribute to violence.¹⁷ Factors included the promotion of cheap alcoholic drinks, having a predominantly male clientele, boring music, overcrowding and high levels of intoxication. Observational research subsequently reported by Homel and colleagues also described how factors relating to the setting were associated with aggression in licensed premises.¹⁸ These factors included ‘the serving and consumption of alcohol, physical comfort, the degree of overall ‘permissiveness’ in the establishment, the availability of public transport, and aspects of “the ethnic mix” of patrons’ (p. 28).¹⁸ Spooner and McPherson described a range of evidence-based environmental measures that management of licensed premises could adopt to reduce alcohol-related violence in and around their premises. These included transport options such as a courtesy bus, server training, security measures such as closed circuit television and metal detectors, crowd control, for example, limiting the number of patrons, ensuring a sufficient ratio of staff to patrons, promoting low-alcohol drinks and the consumption of food, and replacing glass containers with plastic containers.

Research on the influence of the social and physical setting on drug-use behaviours emphasises the importance of shaping the environment to minimise drug problems.

Group affiliation

Drug-specific attitudes, norms and values vary with group affiliation, which can be defined by a multitude of factors such as age, religion, gender, sexual affiliation, and subculture. Drug use can be a way to fit in with, or bond with, a social group. For example, Lovato and colleagues described qualitative research indicating that experimental tobacco use was reported by young people as a way to ‘fit in’ with and bond with their group of friends.¹⁹ Among homosexuals, alcohol and drug use can be a way of fitting into the ‘gay scene’. This can be a potent motivator for young gay men who have recently ‘come out’ and want to establish a new social group that is supportive of their sexual identity. Murnane and colleagues’ research with gay, lesbian, bisexual and queer communities in Victoria identified drug-use patterns that were two to four times higher than might be expected from general population surveys.²⁰ A number of respondents

reported greater awareness of, and access to, drugs after 'coming out' and being active in gay, lesbian, bisexual and queer communities. Some reported that drug use was 'integral to creating and celebrating a sense of community and belonging' (p. 7).²⁰

Moore conducted ethnographic research of drinking among 'skinheads' in Perth, Western Australia, and noted how their culture has been shaped by an ethnic affiliation with English drinking culture.²¹ He described the group's drinking style as heavy, generally in hotels, bars and nightclubs, and fairly 'unabated' from around 7 p.m. until the early hours of the morning, with heavy intoxication reached by about midnight. This pattern of drinking appeared to be conducive to interpersonal violence and was generally associated with behaviour considered to be rowdy and troublesome by the general public. A second pattern was described which was more restrained, often centred around games of pool. Skinheads rarely drank alone. To establish membership with a skinhead group, individuals shaved their head, wore Dr Marten boots and invested time and resources with the group. They did not need to drink to establish membership, but they did need to stand by their 'mates' in violent situations. However, to not drink was considered abnormal.

The cultural influences of the multiple subgroups within society cannot all be covered here. However, the above examples demonstrate that drug use is influenced by the cultural norms and values of the group(s) with which individuals identify.

Influences on drug norms, attitudes and values

Consideration of the factors that influence drug norms, attitudes and values (as described above) enables a study of how harmful cultural influences might be modified. Influences on community drug attitudes and norms include the media, legislation, marketing, broader Western culture (discussed below) and fashion trends. Below is an illustrative summary of discussions on the role of the media, marketing and fashion in relation to cigarettes and heroin.

Wakefield and colleagues conducted an extensive review of research on cigarette advertising promotions, anti-smoking advertising, product placement in movies, on television and in music media, and news coverage about smoking.²² On the basis of the available evidence, they reached a number of conclusions about the ability of the media to shape social values about smoking and to influence smoking behaviours. For example:

Taken together, these studies suggest that cigarette advertising and promotion probably have both predisposing and reinforcing effects on youth smoking, acting as an inducement to experiment with smoking, and reinforcing continued progression towards regular smoking among those who already have tried it. ... these effects generally apply after holding constant the established influence of parental, sibling and friends' smoking. (p. 81)

On the basis of a review of anti-smoking campaigns, Wakefield and colleagues concluded that government-funded anti-smoking campaigns can reduce adult and youth smoking.

Wakefield and colleagues described how, in addition to normal advertising, films have been used as a form of 'product placement' by commercial marketers to promote brands. Portrayals of smoking in popular films were found to occur with much more frequency than could be expected on the basis of smoking prevalence in the general population. They argued that such practices can contribute to adolescents over-estimating the rate of

smoking in the community and regarding smoking as a normal behaviour. One of the few studies of smoking in movies was described:

Compared with non-smoking scenes, smoking scenes positively aroused young viewers (as measured on a seven-point scale from 'boring' to 'exciting'), enhanced their perceptions of smokers' social stature, and increased their intent to smoke. However, showing teenagers an anti-smoking advertisement before the movie nullified these effects. Viewing a movie with the smoking scenes professionally edited out did not change the viewer's liking of the movie. (p. 90)

For further information on the role of the media in youth smoking, Wakefield and colleagues' review article is recommended. Their review describes the many ways in which the media can influence youth smoking and how anti-smoking media messages can counteract these influences.²²

Fernandez discussed how the music industry, Hollywood movies and fashion advertising have influenced perceptions of heroin and heroin use, and how in the late 1990s this portrayal resulted in a trend whereby heroin use was fashionable, aka 'heroin chic'.²³ Fernandez argued that, of all media, film and television have been most responsible for popularising the image of musicians who were heroin addicts, such as Billie Holiday and Miles Davis, as rebel heroes. These portrayals were reportedly presented in a manner that exerted a 'powerful romantic appeal for rebellious youths in search of an identity' (p. 285). In addition, Fernandez described how a number of films (for example, *Pulp Fiction*, *Trainspotting*, *The Basketball Diaries*) have depicted, and in some cases glamorised, heroin use; and how the heroin use of a number of Hollywood actors had been extensively publicised (for example, Robert Downey Junior). In this context, some companies added to the glamorisation of heroin, by featuring models who looked like heroin addicts in their advertising. Fernandez discussed the controversy surrounding such a campaign by Calvin Klein.

In summary, attitudes, norms and values relating to drugs are shaped by a range of factors, including, but not restricted to, the media, marketing and fashion trends. Some of these influences are more amenable to intervention than others. Government cannot (and should not) set fashion trends, nor subvert free speech, but can contribute to media debate, place controls on product promotion and create and support legislation that addresses harmful drug use.

Western culture

This section describes how some features of Western culture have been detrimental to youth development and have contributed to negative outcomes such as youth suicide and drug abuse. Western culture also has many positive aspects and has experienced a number of positive trends. For example, Eckersley described how:

All these cultural trends have benefits to health and well-being: consumerism has contributed to making our lives safer and more comfortable; individualism has enhanced human rights, self-determination and political participation; economism has increased economic efficiency and productivity; postmodernism is associated with greater tolerance and diversity; secularism has helped loosen the chains of bigotry and dogma. (p. 58)¹

While we acknowledge such benefits, the focus of this section is on the negative impacts of western culture and is largely based upon the work of Eckersley, who has written extensively on how Western culture has had detrimental impacts on young people. Further details and evidence for his conclusions are provided elsewhere.^{1 24} Eckersley described a number of 'isms' of modern western culture:¹

- consumerism (often equated with materialism)
- individualism
- economism
- postmodernism
- secularism
- pessimism
- neo-liberalism.

Eckersley argued that consumerism, individualism, economism, postmodernism and secularism have had negative impacts on moral values with the blurring of personal morality into ambivalence and conflict. Materialism has been associated with social alienation, depression, anxiety and anger and negatively associated with life satisfaction. Individualism has been detrimental to the formation and maintenance of attachments.¹ Eckersley noted how these qualities of modern Western culture were particularly detrimental to young people and likely to contribute to the increases in psychosocial disorders observed among young people in the latter half of the twentieth century. Citing Furlong and Cartmel's work,²⁵ Eckersley described the stress, uncertainty and risk faced by young people in modern society:

Furlong and Cartmel describe the increased sources of stress "which stem from the unpredictable nature of life in high modernity". They include the ongoing sense of doubt, the heightened sense of insecurity, the increased feelings of risk and uncertainty, and the lack of clear frames of reference that mark young people's world today. (p. 66)¹

Building upon the work of Corin,²⁶ Eckersley suggested that Western culture fails to provide 'webs of meaning' that frame 'the way people locate themselves within the world, perceive the world, and behave in it'. Looking specifically at the multiplicity of possible reasons for increases in suicide rates since the 1920s, Eckersley wrote:

I believe it is more likely that the results reflect a failure of Western societies to provide appropriate sites or sources of social identity and attachment, and, conversely, a tendency to promote false expectations of individual freedom and autonomy. (p. 68)¹

With regard to secularism, Eckersley cited the work of Elchardus^{27 28} who described the notion of 'cultural flexibility', characterised by 'religious and philosophical indifference, a "here and now" hedonism and an individualism that extends well beyond emancipation from traditional restrictions' (p. 61).¹ Elchardus found cultural flexibility to be related to low education levels, high risk of unemployment, low occupational status and low degrees of autonomy on the job. Accordingly, he argued that cultural flexibility has resulted in legitimisation of increases in uncertainty and low control in the life of people from low socio-economic backgrounds. In the words of Elchardus:

Cultural flexibility ... seems to be a form of withdrawal of commitment and emotion from a social order in which one is losing out. Such a reaction cannot really be considered a form of resistance, let alone revolt, for its very form makes organised action unlikely. Cultural flexibility rather seems to be the meek acceptance of the flexibilisation of one's life for the purposes of economic efficiency and organisational control. (p. 721) ²⁷

More recently, Eckersley expanded upon his arguments regarding the effect of individualism and economism on morals and values:

Modern Western culture undermines, even reverses, traditional (or universal) values. Individuals are encouraged to make themselves the centre of the moral universe, to assess everything from personal relationships to paying taxes in terms of "What's in it for me?" This promotes a preoccupation with personal expectations that keep rising and with wants that are never sated because new ones keep being created ...

Economism is important to values because economics is amoral — that is, it is not concerned with the morality of the choices consumers make to maximise their satisfaction. The more economic choices govern people's lives, the more marginalised moral considerations become. Money itself becomes the dominant value. Social status is ever more narrowly defined in terms of income and wealth, and the 'opportunity costs' of spending time on anything other than making money grow ... The risks of postmodernism include an 'anything goes' morality: a belief that one set of values is no better or worse than another. Values cease to require any external validation or to have any authority or reference beyond the individual and the moment ... The results of this cultural shift include not so much a collapse of personal morality as its blurring into ambivalence and conflict... (pp. 50–51) ²⁴

Eckersley associated these moral changes with a decline in social capital within Western societies, where social capital refers to 'the shared values and norms, trust, cooperation, civic engagement and associations which are the glue that holds societies together' (p. 53). ²⁴

Inspired by Eckersley, we have attempted to identify research that corroborates or negates Eckersley's arguments regarding the impacts of Western culture on drug use (below). While various elements of Western culture (for example, neo-liberalism, individualism) are inextricably linked, we look at each concept separately, to highlight particular aspects of each.

Individualism

In this section, the prevalence of individualism is presented, followed by discussion of the impacts of individualism on society and on drug use in particular. Oyserman, Coon and Kimmelmeier argued that social scientists assume that industrialised Western societies are assumed to be more individualistic (and less collectivist) than other societies. To test whether this assumption was supported by the available literature, Oyserman and colleagues conducted a meta-analysis of international research, comparing samples from 49 countries by both region and country. ²⁹ Individualism domains included independence, striving for personal goals, competitiveness, feeling unique, liking privacy, and articulation of personal opinions. Collectivism was characterised by seeing oneself as part of a group, enjoying being part of a group, feeling duty to group members, concern

for group harmony, decision making in consultation with group members, respect for authority figures and group members, and a preference for group work. The results of Oyserman and colleagues' analysis generally supported the notion of the existence of a Western culture that values individualism and regards collectivism as less important. This was shared by 'America' (United States of America and Canada) and other English-speaking countries (New Zealand, Australia, South Africa), and Western and Central Europe, although Americans were found to be more individualistic than most others. However, there were variations within countries, and other regions were also characterised by high individualism and low collectivism. In their conclusions, Oyserman and colleagues noted that there is 'surprisingly little research' on the structures that maintain individualism and collectivism in a society. They speculated that countries that were high in collectivism made 'obligation to the group salient' and punished those who did not 'promote in-group harmony' (p. 43). Similarly, they hypothesised that individualistic societies used 'practices and symbols to make personal uniqueness salient and to punish those who do not separate themselves from others' (p. 43). If we wish to modify aspects of Western culture that are contributing to problems such as those described by Eckersley and others (above), we need to understand the structures that have created this culture.

Schwartz reviewed the impact of freedom, autonomy and self-determination on the well-being of Americans. He argued that an excess of freedom has resulted in increased dissatisfaction and clinical depression. Modernity has taught us to not accept things as they are and presumes that self-determination (freedom and autonomy) is a psychologically and morally good quality. However, we face an overwhelming range of choices with respect to the way we live our lives. Schwartz described the current situation in the United States of America as such that large numbers of people can live exactly the kinds of lives they want, unconstrained by material, economic or cultural limitations. Modern liberal culture is extremely reluctant to tell people what to do. At the same time there is an explosive growth in the number of people with depression. With reference to the psychological literature, Schwartz outlined possible contributors to this situation. First, increases in experienced control are accompanied by increases in expected control and contribute to unrealistic expectations about life. Second, increased individualism biases causal attributions towards internal rather than external causal factors. Finally, the emphasis on individual autonomy and control may be undermining commitment and belonging to social groups and institutions (an important protective factor for depression). Thus, the current psychological literature on helplessness, control and depression suggests that the influence of freedom of choice is not entirely positive, at least with respect to psychological well-being. Schwartz concluded that aspiring to a culture that offers individuals self-determination without also providing some constraints can be harmful to mental health.³⁰

Individualism has been specifically linked to drug misuse. Knipe discussed how individualism has promoted risk-taking behaviour in American culture, and how this in turn has contributed to illicit drug use by disadvantaged people:

It is through risk-taking behaviours that one can achieve recognition as an individual ... By engaging in these behaviours one can accumulate "cultural capital", esteem and prestige ... How this value is expressed is determined by specific opportunity structures. Being poor precludes risking a fortune on the stock market, driving a race car, or being a stunt pilot; but, within a particular setting, heroin addiction symbolically represents risky business. (p. 170)³¹

That is, illicit drug use provides an affordable means of establishing one's credentials or achieving a positive image in a society in which risky behaviour is valued.

The value placed on individualism has also contributed to community attitudes around self-responsibility, and thus influenced community policies and programs. Phipps has discussed how notions of self-responsibility have contributed to views concerning the support of people in need in different nations.⁴ She noted that:

Evidence from the World Values Survey indicates that Europeans are much more concerned about reducing overall inequality (especially in Norway and the Netherlands); North Americans do not see this as a priority, though levels of inequality are much higher in North America. North Americans (especially those who live in the United States) are more likely to perceive that individuals live in need because they are lazy rather than as a result of, for example, social injustice. This attitude permeates thinking about policy in both Canada and the United States; it is not evident for either Norway or the Netherlands.⁴

An over-emphasis on individualism and a failure to value collectivism result in society blaming people who fail at school, who are unemployed, who are homeless, who develop a drug-dependency disorder or who commit crimes. These outcomes are regarded as the results of individual choices. By blaming people for their own failure, society has little compassion for people with drug problems and takes little responsibility for assisting them. In particular, Australians appear unsupportive of programs that reduce harms associated with drug use but do not aim for drug abstinence. In the 2001 National Drug Strategy Household Survey, a substantial percentage of Australians aged 14 years and over who had never used heroin were not supportive of needle and syringe programs (41%), methadone maintenance programs (36%) or regulated injecting rooms (55%).³² Yet each of these programs has been demonstrated to contribute to harm minimisation.³³⁻³⁵ The drug-prevention slogan 'Just say no' is a clear message on self-responsibility and puts the onus on the individual.³⁶ By blaming individuals, society can feel justified in punitive and uncaring responses to drug-dependent people who do not say 'no' and who commit drug-related offences.

Individualism also affects community views concerning drug control. McAllister noted that the question of how much society should control individual rights underpins drug policy:

The essential question, "to control or not to control", requires consideration of deeply held philosophical beliefs about the nature of society, human freedom and obligations to one's fellow beings. (p. 1)³⁷

If we value individual liberty and individual rights, we would consider it acceptable for people to use drugs and not favour controls on drug use. Data from 2001 National Drug Strategy Household Survey suggest that attitudes towards drug controls are mixed (Table 1). For example, in relation to smoking, 93 per cent of Australians aged 14 years and over favoured stricter enforcement of laws against supplying minors and the majority of the sample favoured bans on smoking in workplaces, shopping centres, restaurants and pubs/clubs, although few smokers supported bans on smoking in pubs/clubs.

Table 1: Support for measures to reduce the problems associated with tobacco use, persons aged 14 and over, by smoking status (per cent)

Measure	Smoker	Ex-smoker	Never smoked
Stricter enforcement of law against supplying minors	84	93	93
Immediate ban on tobacco advertising at sporting events	48	69	73
Making it harder to buy tobacco in shops	29	63	73
Ban smoking in the workplace	55	86	91
in shopping centres	67	88	93
in restaurants	60	89	93
in pubs/clubs	21	68	76

Source: 2001 National Drug Strategy Household Survey, 2002, p. 92 ³²

In relation to alcohol, support for measures to reduce the problems associated with excessive alcohol use also varied according to the measure and whether or not the respondent drank alcohol (Table 2). The measures that received the most support were ‘more severe penalties for drink-driving’ and ‘stricter laws against serving drunken customers’. Increasing the price of alcohol was supported by less than 30 per cent of respondents. Australians seem to favour measures that affect others more than measures that affect themselves.

Table 2: Support for measures to reduce the problems associated with excessive alcohol use, persons aged 14 years and over, by drinking status, Australia, 2001 (per cent)

Measure	Abstainers/ low-risk drinkers (per cent)	Risky/ high-risk drinkers (per cent)
Increasing the price of alcohol	29	6
Reducing the number of outlets that sell alcohol	38	12
Reducing trading hours for pubs and clubs	42	15
Raising the legal drinking age	52	25
Increasing the number of alcohol-free events	76	48
Increasing the number of alcohol-free dry zones	75	50
Serving only low-alcohol beverages at sporting events	74	47
Limiting TV advertising until after 9.30 p.m.	76	58
Banning alcohol sponsorship of sporting events	53	27
More severe penalties for drink-driving	91	81
Stricter laws against serving drunk customers	90	76
Restricting late-night trading of alcohol	63	29
Strict monitoring of late-night licensed premises	80	60
Increasing the size of standard drink labels on alcohol containers	73	58
Adding information on the national drinking guidelines to alcohol containers	78	60

Source: 2001 National Drug Strategy Household Survey, 2002, p. 93 ³²

With regard to controls on illicit drug use, Australians generally did not support their legalisation, although responses varied with the drug and the age of the respondent. ³² Support for legalisation was highest for cannabis (29 per cent) particularly among the 20–29 year age group (42 per cent). This response reflects higher levels of cannabis use compared with other illicit drugs among the general population and younger people in particular. Younger people also tend to be more tolerant in general, less respectful of traditional values or roles, and more demanding of autonomy and control than older people. ³⁸ Less than one in ten Australians supported the legalisation of heroin (8 per

cent), amphetamines (7 per cent) and cocaine (7 per cent). The low level of support for legalisation of heroin, amphetamines and cocaine is likely related to Australians' perceptions of these drugs as causing problems for the community (Figure 2). It appears that Australians are more concerned about their individual right of freedom from harm from drug use by other people than individual rights to use drugs.

In light of the growth of, and negative impacts of, individualism, Maton has argued that society needs to be more thoughtful of others, that is, we need to become a more caring society.³⁹ This is further discussed below.

Neo-liberalism

Neo-liberalism is a modified form of traditional liberalism, particularly based upon a belief in free market capitalism and the rights of the individual. Many agree with Eckersley's negative view of neo-liberalism.⁴⁰⁻⁴³ For example, Coburn has argued that neo-liberalism produces both higher levels of inequality and lower levels of social cohesion.⁴⁰ In a paper published in 2004, Coburn described relationships between neo-liberalism, welfare regimes and health outcomes.⁴¹ He noted that economic globalisation has resulted in business re-emerging as the dominant class within society. This dominance is now on a global scale as well a national scale. He described how this dominance has been associated with neo-liberal policies and has resulted in a reduction in worker and citizen rights and a reduction in the welfare state. This in turn has forged increases in social inequality, poverty, income inequality and social fragmentation, which have subsequently resulted in health inequalities. However, he noted that neo-liberalism has had different effects on different nations because of national variations in class structure and the institutionalised form of the welfare regime. He described three major types of welfare state:

the Social Democratic welfare states, showing the greatest decommodification and emphasis on citizenship rights; the Liberal welfare state which is the most market-dependent and emphasises means and income testing; and an intermediate group, the Conservative, Corporatist or Familist welfare states, which are characterised by class and status-based insurance schemes and a heavy reliance on the family to provide support. These countries might be viewed as strong, weak and intermediate or mixed-type welfare states, respectively. (p. 44)

Coburn reported that countries with social democratic forms of welfare regime have better health than do those whose focus is more neo-liberal. For example, epidemiological data demonstrate that infant mortality is lower, the potential years of life lost (number of years death occurs before age 70) are less, and the proportion of people alive at age 65 is higher in countries with social democratic regimes relative to countries with liberal regimes. He described how individuals and families in more neo-liberal societies need to rely on individually purchased health-related societal resources whereas health services are more universally available in less neo-liberal regimes.

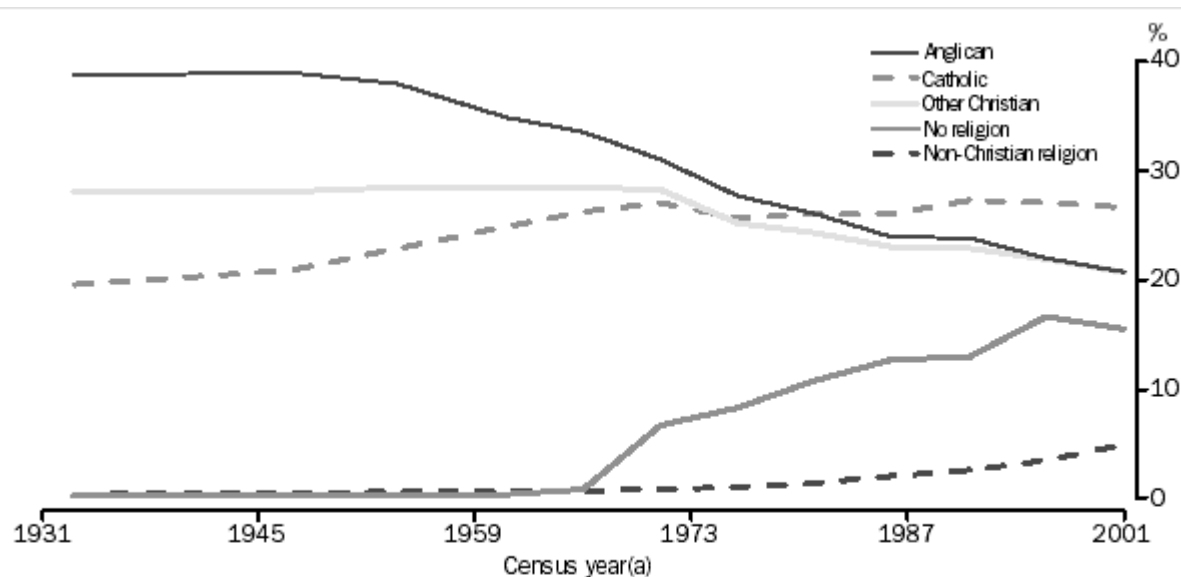
With such analyses of the negative impacts of neo-liberalism on society and health, a singular concern for economic growth, particularly in the context of the dismantling of the welfare state, appears to be misguided. We need to be more concerned with population health or at least as concerned with population health and well-being as we are with supporting business. Drug-dependent people, who are typically the most in need

of societal supports, are among the most vulnerable to reductions in the worker rights and social services described by Coburn and others.

Secularism

Secularisation refers to the declining influence of religion. ⁴⁴ Giddens has reported how, with the exception of the United States of America, industrialised countries have experienced considerable secularisation. ⁴⁴ He presented data that demonstrated reductions in levels of membership of religious organisations; the social influence, wealth and prestige of religious organisations; and religious values and beliefs. ⁴⁴ Consistent with the trends reported by Giddens, data from the Australian Bureau of Statistics indicate an increase in the percentage of people reporting that they had 'no religion' between 1960 and 2001 (Figure 3). ^{45 46}

Figure 3: Religious affiliation of Australians of all ages



(a) Censuses were conducted in 1933, 1947, 1954, 1961, and subsequently at five-yearly intervals to 2001.

Source: Year Book Australia 2003 (cat. no. 1301.0) ⁴⁶

As religious organisations have lost moral authority in society, and fewer people feel concerned about 'going to hell' for 'bad' behaviour, we now rely more on formal (for example, laws) rather than informal means of behaviour control. Halpern reviewed international data on values and morals and identified a 'reduction in the universality of norms, values and constraints at the informal level' (p. 383), ³⁸ which was manifested by greater individualism, libertarian values and higher tolerance in the personal sphere. At the same time, there has been an 'expansion in the extent of norms, values and constraints in the formal domain, most obviously in the legal sphere, but also in many other areas such as health, education and welfare' (p. 383). ³⁸

With the reduction in religiosity, people are looking for alternative sources of meaning. Many are finding meaning in work. ^{47 48} This is likely to have contributed to the higher rates of parents working and people working long hours, ⁴⁹ which in turn contributes to parents being less available to supervise their children. In the search for meaning, some people have adopted alternative religions such as Buddhism or cults, ⁴⁴ while others find

meaning and a sense of belonging by following celebrities.⁵⁰⁻⁵² Some researchers have also suggested that the rise of materialism, discussed below, in part reflects this search for meaning.

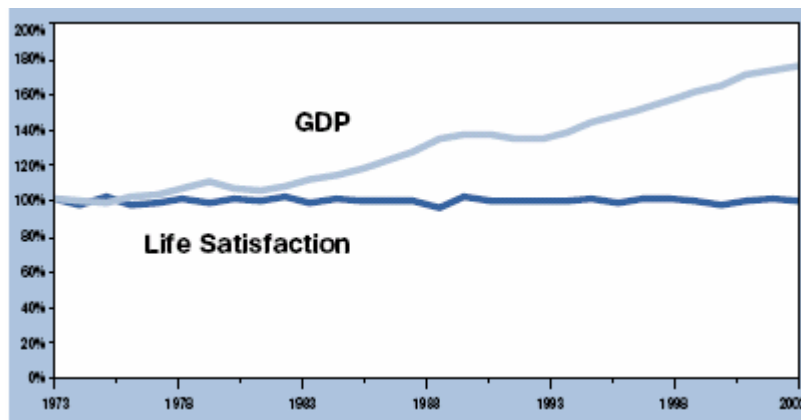
At an individual level, religiosity has been found to be protective against tobacco use, alcohol use, cannabis use and other illicit drug use.⁵³⁻⁵⁹ However, the relationship between religiosity and drug use is not simple. Nonnemaker, McNeely and Blum investigated the association between public and private domains of religiosity and various adolescent health-related outcomes,⁵⁸ where public domains of religion included frequency of attendance at religious service and participation in religious youth-group activities and private domains of religion included frequency of prayer and importance of religion. Consistent with previous research, Nonnemaker and colleagues found that both public and private religiosity were protective against the use of cigarettes, alcohol and cannabis. More specifically, their results indicated that private religiosity was more protective against experimental drug use, while public religiosity was associated with regular use, particularly of cigarettes. They also found that both public and private religiosity were associated with a lower probability of having engaged in violence in the past year as well as a lower probability of having ever had sex. Only public religiosity was associated with lower emotional distress and only private religiosity was associated with a lower probability of having had suicidal thoughts or having made a suicide attempt.⁵⁸

With the increase in secularisation, we need other ways to develop shared values, meaning in life and sources of authority, particularly for children and adolescents. This issue is discussed further below.

Materialism–consumerism

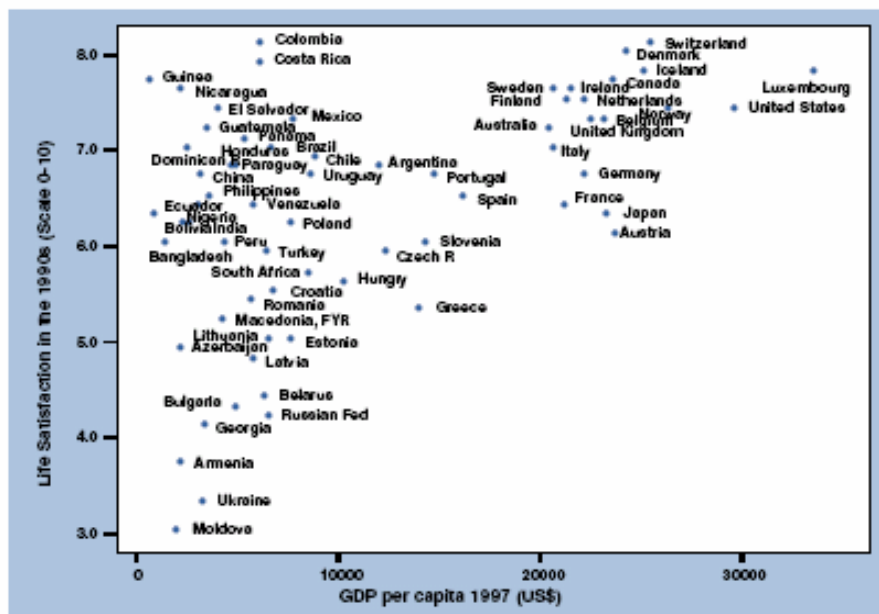
Hamilton has written extensively on materialism and consumerism in modern society. He argued that material wealth has not produced happiness, and has actually contributed to unhappiness.⁴² He reported research that identified that, despite Australia being one of the wealthiest countries in the world, 62 per cent of Australians lamented that they did not have enough money to buy what they want.⁶⁰ Consistent with Hamilton's argument, the New Economics Foundation presented international data that indicated that wealth does not necessarily contribute to well-being.⁶¹ For example, they presented data from the United Kingdom Life Satisfaction Survey that showed that increasing national wealth was not associated with an increase in life satisfaction (Figure 4).⁶¹ A second example is provided by an international comparison of life satisfaction and national wealth, which demonstrated that people from many developing countries reported levels of life satisfaction that were the same as levels of life satisfaction reported in much wealthier countries (Figure 5).

Figure 4: National wealth and life satisfaction in the United Kingdom



Source: Shah, 2004, p. 5⁶¹

Figure 5: An international comparison of national wealth and life satisfaction



Source: Shah, 2004, p. 7⁶¹

Hamilton outlined what he described as the preoccupation of the modern political process with economic growth (which he calls ‘growth fetishism’) and noted that, despite high and sustained levels of economic growth in the West in the past 50 years, people are no more satisfied with their lives.⁴² He suggested that this demonstrated that growth fetishism had for the most part failed to improve people’s lives and instead had produced a seriously sick society.

Growth not only fails to make people contented; it destroys many of the things that do. Growth fosters empty consumerism, degrades the natural environment, weakens social cohesion and corrodes character.

The richest people in the world are saying they are miserable, that it’s not worth it and, most disturbingly of all, that the process of getting rich causes the problems. Continued pursuit of material acquisition gives rise to inner conflicts that become manifest in society in various ways. (p. 15)⁴²

Consumer capitalism's answer to meaninglessness is the seeking of a proxy identity in the form of commodity consumption.

People continue to pursue more wealth and consume at even higher levels because they do not know how better to answer the question "What do I do now?" (p. 106)

(The) preoccupation with growth and material acquisition inevitably causes consciousness to shrink. The mind that 'meditates' at the shopping mall can never expand to encompass the intrinsic values of the natural world; it can only look upon it as a mine that provides the resources to make the goods that are consumed or as a dump into which can be discarded the goods we have tired of. (p. 194)

Pitman, Herbert and colleagues argued that the focus on materialism/consumerism is likely to have contributed to the increase in the percentage of adolescents engaged in part-time work in Australia.⁶² This is problematic on a number of levels. Firstly, for those who work long hours outside school, this involvement could interfere with schoolwork and homework, as well as with normal recreational and social activities. Secondly, high levels of disposable income/adolescents working represent a risk factor for drug use.⁶³⁻⁶⁵ For example, Schulenberg's review of the literature identified that increased work hours during high school years were causally related to alcohol use.⁶⁶

How can materialism, or the negative impacts of materialism, be reduced? While Eckersley²⁴ and Hamilton⁶⁷ have identified that there is a shift back to more community-minded, less materialistic values among some subgroups of society, this is not a basis for complacency about the issues raised above. While noting how difficult it is to change cultural norms, Shah and Marks outlined a number of areas in which policy can discourage materialism.⁶¹ These included banning commercial advertising to under 8-year-old youth, who do not have the critical capacity to understand the false advertising claims that purchasing products will make them happier. They noted that Sweden has implemented a ban on advertising aimed at children less than 12 years. A second approach is to provide cheap options for local leisure pursuits, to engage people in activities other than watching television and shopping.

Conclusion and suggestions for cultural transformation

In conclusion, the research and debate around the impacts of Western culture suggest that Western cultural values have become increasingly influenced by individualism, neo-liberalism, materialism and secularism. While there have been some benefits from these Western cultural trends, the problems they cause need to be addressed. For example, people have become more concerned about themselves and feel less concerned about (or responsible towards) others in society who are not doing well, particularly people with drug problems. These trends can influence risk factors for drug abuse and the environment of drug users at a number of levels. At the individual level, risk factors for drug use such as social alienation can be increased and social support can be decreased. At the environmental level, social support systems can be compromised. 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, workplace ('family friendly' or profit-driven) policies, provision of childcare, welfare policies.

Further, the negative impacts of western culture discussed above tend to be disproportionately experienced by people from low socio-economic groups, while wealthier people are able to enjoy more of the benefits of modern Western society (for example, material acquisition, personal freedoms).⁶⁸ Eckersley noted that:

In terms of socio-economic differences, consumerism and economism, for example, would cause most stress among low-income groups because of the emphasis they place on money and material well-being. (p. 61)¹

Maton has argued that, as the causes of social problems are contained within the social environment, we need to transform the social environment:³⁹

deeply troubled schools, violent neighborhoods, disaffected peer groups, family poverty, inadequate support systems, and limited opportunities for purposeful social engagement are some of the proximal environmental causes of urban social problems such as school failure, teenage pregnancy, delinquency and youth violence. (p. 27)

Taking an ecological perspective, he noted that the proximal social environment is influenced by the larger community environments and systems in which they are embedded:

dysfunctional school and human service systems, lack of well-paying jobs and community resources for poor families, racial and gender discrimination, intergroup conflict and socioeconomic disparities. (p. 28)

These larger community environments are themselves embedded within larger national and international economic, political and cultural institutions and systems which constitute 'the roots of economic dislocation, discrimination, mass society, a culture of violence, and corporate greed' (p. 28). Maton argued that current attempts to address social problems are limited because they do little to affect the social environments in which the social problems are embedded. To change this environment, Maton described a 'strategic vision for social transformation' (p. 27) with four foundational goals: capacity building, group empowerment, relational community building, and culture-challenge. To achieve these goals, Maton identified four dimensions of the social environment that need to be changed: the instrumental environment for capacity building, the structural environment for group empowerment, the relational environment for community building and the cultural environment for culture-challenge. Maton's ideas for each of these environments are summarised below.

The instrumental environment comprises the core methods, problem-solving capability and leadership used to achieve core goals. For example:

The failure of schools to adequately educate, families to socialise, human services to serve those in need, and governments to govern, for instance, are failures at the instrumental level. (p. 30)

Capacity building — a participatory, self-help, assets-based approach to enhancing instrumental capacity — was proposed as the transformational goal in this environment. Maton provided examples of capacity building within school settings (school transformation using participatory, problem-solving methods), in local communities (employing techniques such as coalition building, community-based economic development and comprehensive neighbourhood revitalisation), and at the societal level (strengths-based capacity-building social policies that regard citizens as valuable assets and as self-determining agents rather than as people with deficits, for example, the provision of resources to community groups for programs that support child, youth, family, school and community development).

The structural environment relates to the ‘distribution of resources and power across groups, and the presence of viable opportunity structures that allow disenfranchised groups access to valued resources’ (p. 33). Maton noted that: ‘Where large discrepancies in resources and power exist, and opportunity structures are inadequate, a debilitating sense of powerlessness, and ensuing negative social outcomes, may be expected’ (p. 33). Thus, increasing the access of marginalised groups to economic, political and psychological (for example, self-efficacy and self-esteem) resources is critical for achieving social transformation.

Maton provided examples of strategies for empowerment at the level of community settings. These included participation in a variety of voluntary associations; social action approaches, such as grass-roots organising or participatory action research; and social movements such as the women’s movement. Maton emphasised the valuable contribution that academics can make at each level, through the ‘provision of ideas and data that help fuel activism’. In this regard, the funding of drug user groups in Australia, such as the New South Wales Users Association and the Western Australian Substance Users Association, is a valuable strategy towards empowering drug users in society.

The relational environment encompasses the quality and nature of inter-group and personal relationships. Maton noted that:

social environments characterised by high levels of support, belongingness, cohesion, cooperation and trust contribute to positive socioemotional and behavioural outcomes ... a basic cause of many social problems, and a contributing factor to their apparent intractability, is a serious weakening in the overall social-relational fabric, i.e. the erosion of community. (p. 36)

Maton provided examples of various approaches being pursued at the setting level, including schools where cooperative norms and practices have been shown to make a difference in the development of a supportive school community, and geographic communities where opportunities for connectedness have benefits for all involved, including those who have been traditionally disconnected (for example, mentor programs and home-visiting programs for isolated or at-risk families). Maton argued that, if a critical mass of such programs can be achieved, the level of connectedness between all residents of a community should be enhanced. He noted, however, that a major challenge in relational community building is connecting the many different groups within a community that might be antagonistic towards each other. Towards this end, he suggested encouraging opportunities for inter-group contact and identifying and encouraging leaders whose vision and practices encompass the whole community.

The cultural environment encompasses the belief systems, values, norms, traditions and practices of society. Maton argued that two facets of American culture ‘other-denigration and self-absorption’ (p. 39) underlie many social problems. This argument appears to be relevant to other Western cultures such as Australia. In such a culture people who are regarded as different are denigrated and regarded as inferior. A culture of privilege further compounds the problem. Self-absorption, due to ‘excessive consumerism, individualism, and careerism, severely limits our potential to mobilise social and economic resources for the larger, public interest’ (p. 39). Maton noted that challenging these cultures is difficult as they are so ingrained. However, he provided some examples of structures that can contribute to culture-challenge including progressive social action or political groups and religious organisations that advocate social paradigms counter to the cultural mainstream. He highlighted the role that ‘new social movements’ have played in recent decades to raise concerns about the role of women, the environment and human rights. Maton argued that social scientists can contribute by being active in such movements and engaging in public debates.

Maton has provided a wealth of ideas for addressing the problems associated with Western culture discussed in this chapter. His recommendations (for example, the need to create supportive and inclusive communities) are relevant to preventing problematic drug use as well as assisting drug-dependent people. The transformation of these ideas into action is not somebody else’s job. It requires the concerted effort of academics, policy makers, politicians, service providers and every member of a community.

Social categories and social exclusion

As discussed in the introduction to this chapter, the term ‘social structure’ can refer to the roles, relationships and domination associated with societal categories such as class, gender and race or ethnic group. The impacts of these categories on health in general and drug use in particular are discussed in this section. First, however, a discussion of the impacts of discrimination and social exclusion on health and drug use is presented. The experiences of discrimination and social exclusion can result from one’s class, gender, ethnic group or other characteristics used to classify individuals in society, including drug dependence.

People experience prejudiced attitudes and negative discrimination for a number of reasons. Specific forms of prejudice include racism and sexism. People also experience prejudice because they are unemployed, homeless, have a mental health problem or a drug-use disorder.

Krieger reviewed the literature on the impact of discrimination on health and identified that discrimination appears to be detrimental to physical and mental health.⁶⁹ She explained that the relationship is not clear and appears complex; however, discrimination is likely to affect health via exposure, susceptibility and responses to:

- economic and social deprivation
- toxic drugs and hazardous conditions
- socially inflicted trauma
- targeted marketing of legal and illegal drugs and other harmful commodities
- inadequate health care.

One of the impacts of discrimination can be social exclusion, which is a process by which people are denied the opportunity to participate in society and are unable to

contribute to society.⁷⁰ Social exclusion is now regarded as an important health risk factor,⁷¹ as demonstrated by the establishment of the Social Exclusion Unit by the United Kingdom Government.⁷²

A substantial body of research literature highlights how drug-dependent people tend to be marginalised, which can contribute to a vicious cycle of disadvantage, discrimination and drug abuse.⁷³⁻⁷⁵ For example, Ritson described how stigmatisation of drug-dependent people, based upon the belief that drug dependence is the fault of the individual, can create a barrier to seeking treatment.⁷⁶ Room reviewed the literature in this area and described a number of ways in which drug-dependent people are marginalised:

- In a 14-country study by the World Health Organization, disapproval was stronger for being a 'drug addict' than for having a criminal record for burglary.
- Studies from the United States of America, Britain and Australia indicated that the general population thought that smokers, 'high' alcohol users and illicit drug users should all receive lower priority in health care. Studies of health care provision demonstrate, in fact, that inferior care is given when the patient is regarded as a 'skid-row drinker'.
- People in treatment for drug-dependence problems demonstrate substantial social marginalisation: they tend to be unemployed or in marginal jobs, to be divorced or separated, to be homeless.⁷³

Room described the marginalisation of drug-dependent people as coming from multiple sources, including family friends, social agencies, and policies at the local, state or national level. For example, Room noted: 'policy decisions to be "tough on drugs" always carry the potential to marginalise those who do not conform' (p. 10).⁷³

The issue of stigmatisation is also relevant for young people who might not have a drug-dependency problem. Kaplan and Johnson found that the strongest predictor of increased drug use among young people was the effects of specific labelling as a 'drug user'. That is, drug use increased as a result of getting into trouble because of initial drug use. Kaplan and colleagues explained that negative social sanctions (labelling) led to an escalation of drug use via three paths: (a) by perceiving the label of 'drug user' as a positive thing, young people who use drugs can have a more positive self-evaluation and greater self-acceptance; (b) having been alienated by society because of being a drug user, the young person loses motivation to conform to that society; and (c) having been alienated by society because of being a drug user, the drug user has less opportunity to socialise with non-drug-using groups, hence greater opportunity and encouragement to use drugs. Being labelled as a 'drug user' is a powerful phenomenon that can give adolescents the identity they have been searching for, as per their developmental task. By serving the purpose of supplying a ready-made identity and social group, such labels can contribute to youth drug use.⁷⁷

In summary, it is apparent from the research literature that drug users can be labelled, stigmatised and often marginalised. Labels can contribute to self-identify; marginalisation can affect the availability of social supports, the quality of service provision and treatment seeking. Consequently, labelling and marginalising drug users can exacerbate drug-use problems.

Class

The relationship between class and health is well established.^{78 79} Najman and Davey Smith outlined the findings regarding class-related health inequalities on which there is general agreement⁸⁰.

- Social classes live in significantly different worlds. Almost every domain of life is associated with class location.
- Class-related inequalities in mortality rates are observed in almost every country for which data are available.
- These inequalities in mortality are observed for causes of death that make up well over three-quarters of all deaths.
- These inequalities are found for all age groups from infancy to childhood, adolescence, adulthood and old age.
- The magnitude of these inequalities varies from country to country, as well as over time in particular countries, and many reflect differing magnitudes of socio-economic inequalities or levels of social investment.
- Social class and socio-economic and income inequalities are all distal predictors of health inequalities. Lifestyle and behaviours have been the most researched proximal factors associated with premature mortality.
- More recent research has identified socio-economic inequalities acting during the foetal and childhood period as contributing to adult health inequalities (p. 3).⁸⁰

As summarised by Wilkinson and Marmot, the effects of social position impact all people across the life course and along the gradient from the poorest to the wealthiest, resulting in what is known as the 'social gradient':

Poor social and economic circumstances affect health throughout life. People further down the social ladder usually run at least twice the risk of serious illness and premature death as those near the top. Nor are the effects confined to the poor: the social gradient in health runs right across society, so that even among middle-class office workers, lower ranking staff suffer much more disease and earlier death than higher ranking staff. (p. 10)⁷¹

Graham presented an overview of the multiple models of social determinants of health, and noted a common pattern whereby social position is the point of each model at which societal resources enter and affect the lives of individuals. Societal resources include 'social resources like education, employment opportunities, and political influence, as well as material resources like income and property' (pp. 107–108).² Further, social position then influences access and exposure to a set of intermediate factors that affect health, in the social and material home environment, community environment and work environment. Because of the importance of social position to determining access to resources that are important at every point of the causal chain to health outcomes, Graham described social position as the 'fundamental social cause of health' (p. 112). She noted that research on social position to date has focused on socio-economic position, but should be broadened to encompass ethnicity, gender, sexuality and any other factor that determines social position.

Many sociologists have moved away from structuralist approaches. Furlong reviewed discussions of the move away from class structure towards individualism.⁸¹ Furlong found little evidence to support abandoning the notion of class effects, but noted that

belief in the power of individuals over and above class effects has, in fact, resulted in individuals feeling unduly responsible for personal failures:

there is little evidence to suggest that class inequalities are weakening on an objective level; indeed, structural changes have been associated with the risk of long-term unemployment and social exclusion for some young people, while even those from relatively advantaged social backgrounds experience discontinuities. On the other hand, there is evidence that class cultures are weakening and that the subjective experience of risk is present throughout the class structure. In these circumstances, a process of individualisation can be identified in which young people increasingly hold themselves responsible for their fate in the labour market, rather than being able to acknowledge the extent to which broader structures of power and inequality affect their life chances. (pp. 596–597) ⁸¹

While substantial attention has focused on the effects of low socio-economic status on drug use, health and well-being, this does not mean that people in higher socio-economic groups do not have drug-use problems. In fact, Luthar discussed evidence of problems among affluent youth in relation to drug use, anxiety and depression. ⁸² For example, Luthar noted that data from the Monitoring the Future study in the United States showed that the Grade 12 students from high socio-economic backgrounds reported the highest rates of use of cannabis, inhalants and tranquillisers. After reviewing the literature, Luthar concluded that two main factors appear to be associated with higher rates of drug use, anxiety and depression among affluent youth, namely, excessive pressures to achieve and physical and emotional isolation from their parents. Further, Luthar noted that classism can be directed at the rich, who are as concerned with being liked as anyone else. On the costs of material wealth, Luthar stated:

At the individual level, inordinate emphasis on material success can limit attainment of other rewards critical for well-being, such as close relationships. At the community level, material affluence can inhibit the formation of supportive networks, as services tend to be bought and not shared. At the systemic level, the subculture of affluence emphasises personal autonomy and control, with the associated dangers of blaming oneself when control is not achieved. (p. 1590) ⁸²

Thus class impacts in complex ways on drug use, health and well-being. The impacts of socio-economic position on drug use are described in Chapter 3.

Graham suggested a number of policy implications relating to the importance of social position for health that are relevant to minimising drug problems. ² First, health policy targets should aim not just to improve health, but to reduce inequalities in the distribution of health outcomes. For example, it is not sufficient to aim to reduce population smoking rates if smoking rates are higher among particular social categories. Targets need to be set to reduce the inequalities in smoking. Second, while health programs targeted at disadvantaged groups are an important element of an equity strategy, they are not sufficient, as they do not address the factors that create the inequality in the first place. Employment and fiscal policies and the provision of public housing, education and social security are needed to improve the living standards of the disadvantaged.

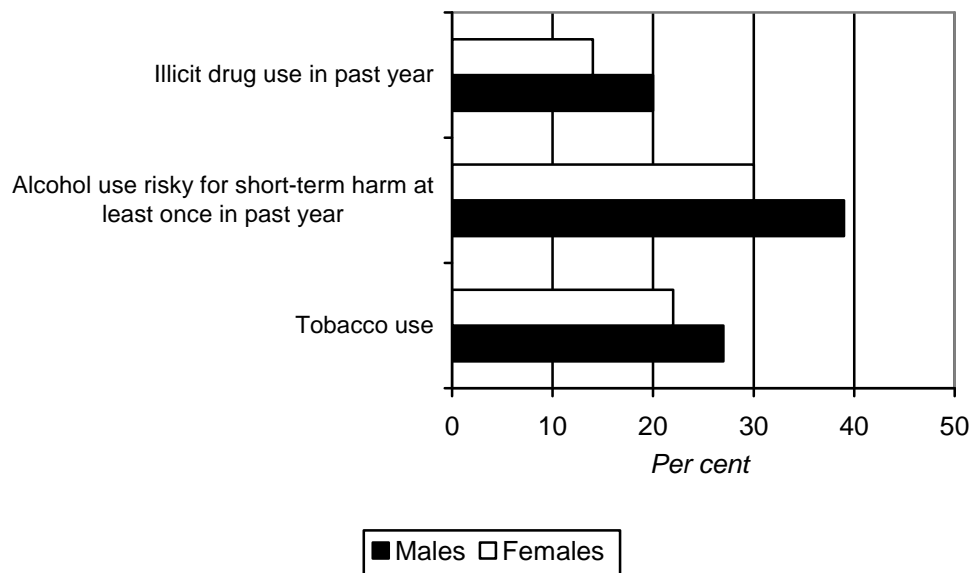
Gender

Rutter, Caspi and colleagues noted that scientists have differentiated between ‘sex differences’ (denoting differences with a biological origin) and ‘gender differences’ (differences with a socio-cultural origin).⁸³ They argued that it is artificial to separate biological and socio-cultural origins, as they are not independent. Consequently, they use the terms ‘sex’ and ‘gender’ interchangeably. Accordingly, the terms are used in this undifferentiated manner in this report.

Description of differences

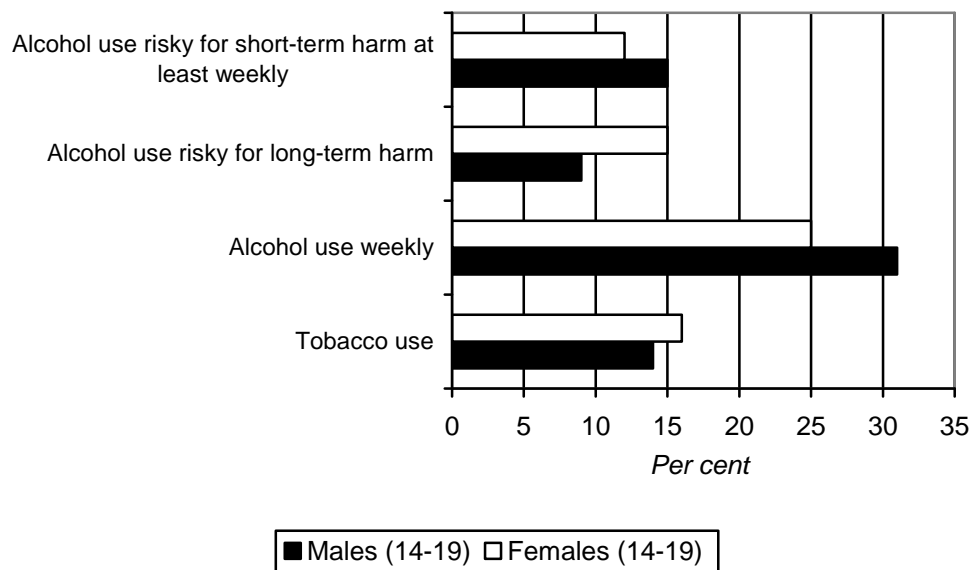
Gender differences exist in relation to most health and well-being outcomes. For example, women live longer than men,⁸⁴ males are more likely to engage in antisocial behaviour,⁸⁵ and the pattern and onset of psychiatric disorders differ with gender.⁸³ Drug use and drug outcomes also differ by gender. For example, data from the National Drug Strategy 2001 Household Survey, illustrated in Figure 6 and Figure 7, identified generally higher rates of drug use among males than females.⁶ An exception to this pattern was alcohol use that placed the drinker at risk of long-term harm was higher among adolescent females than males.

Figure 6: Drug use by gender, Australians aged 14 years and older



Source: National Drug Strategy 2001 Household Survey, 2002 ⁶

Figure 7: Drug use by gender, Australians aged 14–19 years



Source: National Drug Strategy 2001 Household Survey, 2002 ⁶

Gender differences in drug use are also evident internationally. For example, Wilsnack and colleagues analysed data from general population surveys on drinking in ten countries (Australia, Canada, Czech Republic, Estonia, Finland, Israel, Netherlands, Russia, Sweden and the United States). Where data were available, they compared percentages of men’s and women’s alcohol use in terms of lifetime abstainers, current drinkers, mean monthly frequency of drinking, millilitres of ethanol per occasion, heavy drinking, intoxication, family problems, occupational problems and morning drinking. Men were less likely to be lifetime abstainers than women, and male drinkers drank more frequently, in larger amounts and with higher rates of adverse consequences than female

drinkers.⁸⁶ The pattern of gender differences was fairly consistent across the ten countries examined.

Gender differences also exist in specific drug-use behaviours. For example, a number of studies describe differences between the drug-use behaviour of male and female injecting drug users. Evans and colleagues described how female injectors in San Francisco were more likely to be injected by another person than male injectors, even after adjusting for years injecting, being in a relationship with another injecting drug user, and other potential confounders.⁸⁷ Whynot summarised literature on the social context of risk for women who inject drugs, and argued that the experience differed for women relative to men. Whynot noted differences in the influence of sexual and physical victimisation, violence, comorbid emotional or psychiatric conditions and social networks. For example, women's drug injection practices were more likely to be affected by close personal relationships than men's, with women less likely to inject alone, more likely to have an addicted partner and more likely to be injected by a partner than men. Whynot noted that gender also affects the ability of women to utilise treatment programs due to social and legal concerns and issues relating to care of children.⁸⁸

Problem behaviours and outcomes associated with drug use also differ by gender. For example, a study of income generation by heroin users in south-western Sydney identified that, while males and females were equally likely to commit property crime to generate income (38 per cent), males were more likely to generate income from involvement in the drug market than women (52 per cent compared with 24 per cent), while women were more likely to generate income from prostitution than men (16 per cent compared with 1 per cent). Women who are drug-dependent are more likely to report experiences of sexual assault⁸⁹ and have higher rates of psychiatric morbidity than drug-dependent men.^{90 91}

Thus, gender differences exist in patterns of drug use, related behaviours and outcomes. However, gender differences in patterns of drug use are complex (favouring males in some instances, females in others) and are converging over time.^{92 93}

Explanations for gender effects

Rutter, Caspi and Moffitt discussed how reported gender differences in psychopathology (including drug and alcohol use disorders) can result from the complex interaction of a combination of factors, including methodological artefact, genetic differences and their consequences, differential exposure to social factors and differential responses to risk factors.⁸³ Methodological artefacts include, for example, differential reporting by males and females and differential presentation of symptoms by males and females in regard to the same underlying disorder. Consequences of being genetically male or female include, for example, gender differences in patterns of maturation, cognitive styles and risk taking. Examples of differential exposure to social factors include differential parenting and social responses to behaviours, different friendship patterns and different styles of peer groups in adolescence for males and females. Differential responses to risk factors include, for example, greater sensitivity among women to stresses involved in getting on with other people, greater sensitivity among men to divorce/separation and to work problems, and stronger risks for suicide in males than in females after unemployment and retirement.⁸³

Denton, Prus and Walters tested the impacts of differential exposure to risk factors and differential vulnerability to risk factors on gender differences in health using Canadian National Population Health Survey data.⁹⁴ They identified both differential exposure and differential vulnerability and concluded that the social structural and psychosocial determinants of health were more important for women and that behavioural determinants were more important for men:

That is, our findings show that the pathways through which structural, behavioural and psychosocial forces influence health are different for men and women. The exposure hypothesis proposes that gender-based health inequalities are largely the result of the differing social locations of men and women, their differing lifestyle behaviours and the differing number and levels of chronic stressors and life events experienced by men and women. Nonetheless, gender differences in health are only minimally reduced by controlling for exposure to structural, behavioural and psychosocial forces; significant gender differences remain. The vulnerability hypothesis proposes that women's health differs from men's because they also react in different ways to factors that determine health. While we found that there is considerable commonality in the social predictors of health, there are indeed important gender differences. First, age, family structure, main activity, education, income, occupation and social support are important structural determinants of health for both genders, although their effects differ for men and women. Second, smoking, alcohol consumption and physical activity are more important determinants of health status for men and body weight is more important for women. Third, the impact of childhood/life events, chronic stressors and psychological resources play an important role in determining health, but their effects are generally stronger for women than men. (p. 2598)⁹⁴

Thus, differential exposure to risk factors and differential responses to risk factors influence gender differences in health and drug use. Looking specifically at gender differences in youth drug-use patterns, the Health Education Unit reviewed the literature and identified a number of ways in which gender-specific norms and expectations affect youth drug use.^{95 96} For example, in the context of social value placed on slenderness for females, research has shown that teenage girls who express weight concerns are more likely to smoke, and to see smoking as a means of weight control. The Health Education Unit noted that tobacco marketers have identified and capitalised on this: 'Specific brands and marketing strategies recruit females to smoking through the promise of freedom, self-confidence and slimness' (p. 27).⁹⁵

Gender-specific social influences are changing, and this process is likely to be contributing to the telescoping effect (reduction in the male–female differences in drug-use patterns) that is evident. Aube, Fleury and Smetana described three major changes experienced by women in the past 50 years: increased participation in the paid labour force, changes in domestic labour and childcare patterns, and increased numbers of female-headed single-parent families.⁹⁷ For example, they described the increases in the participation of women in the workforce, increases in education levels, and marrying and having children later in life. However, they noted that women still earn less than men and are more likely to be employed in lower-status temporary and part-time positions than men. After reviewing the evidence on the impacts of female participation in the workforce, Aube and colleagues concluded that the increased participation in work was not harmful to the mental or physical health of women or to the adjustment of children.

However, they did recommend continued affirmative action policies to address gender inequities in pay and status, more and generous leave provisions and workplace policies (for example, flexible time) to assist women to balance work and family life.

While women have increased their role in the workplace, they have continued to retain most of the responsibility for domestic duties, resulting in lower levels of marital satisfaction and higher levels of psychological problems among women than men. Policies that enable men to also participate more fully in domestic life (such as generous leave and flexible hours) were proposed by Aube and colleagues to encourage males to share the burden of domestic duties, including raising children. However, they noted that, even when such policies exist, men are slow to utilise these programs and increase participation in domestic duties. Aube and colleagues asserted that: 'It is clear that dramatic attitudinal change is necessary if greater domestic equality is to be achieved and that such change needs to begin at an earlier age' (p. 645). School programs teaching parenting skills to boys were suggested as one means to achieve such cultural change. Aube and colleagues discussed the increased rate of sole-parent families and the finding that children of these families are more likely to have psychological and behavioural problems, largely due to the post-separation/divorce poverty, paternal absence and continued parental conflict. Various policy initiatives to address these outcomes were proposed, including enforcement of paternal child support, promoting paternal involvement with children after divorce/separation, and school programs to assist children who experience post-divorce/separation conflict. The issue of sole-parent families is discussed further in Chapter 6.

In summary, there are a multitude of gender-related differences in the risk factors for drug use, drug-use behaviours and drug-related problems. Social trends are changing the nature of these gender differences. Drug prevention and treatment programs need to appreciate the biological differences and different social contexts that influence male and female drug-use behaviours and experiences. Social and workplace policies need to address differential exposure and susceptibility to risk factors.

Ethnicity

Australia is an ethnically diverse country. Since British settlement in 1770, Australia has experienced a series of waves of immigration from different countries and for different reasons. For example, following the Second World War Australia negotiated agreements with other governments and international organisations in an attempt to achieve high migration targets. These agreements affected residents of a number of European countries, British and American ex-servicemen, and displaced persons from refugee camps in Europe. In addition to planned migration agreements, economic and humanitarian events around the world subsequently influenced the size and source countries of the Australian program. For example, Australia accepted significant intakes of refugees from Hungary following unrest in 1956, from Chile following the overthrow of the Allende government in 1973 and from Indo-China after the end of the Vietnam War in 1975.⁹⁸ Consequently, we have an ethnically diverse population, and each ethnic group has a different history (and level of acculturation). At the time of the 2001 census, 22 per cent of the Australian population was born overseas — 11 per cent in Europe, 5 per cent in Asia and 1 per cent in the Middle East and North Africa. The Australian population reported over 200 different ancestries and 20 per cent of the population reported speaking a language other than English at home.⁹⁹ Given the above statistics, it is clear that ethnicity is not a dichotomous concept of ethnic–non-ethnic, nor a continuous variable from low to high ethnicity.

Pearce described how the concepts of genetics, race and ethnicity are commonly confused.¹⁰⁰ Race is usually used to denote biological differences between major racial groups: Africans, Caucasians, Pacific Islanders, Asians and Native Americans. However, Pearce and colleagues noted that human races 'are not and never were pure, and such broad continental groupings explain little in terms of the overall genetic variation of humanity' (p. 1070).¹⁰⁰ Further, he argued that any impacts of genetic factors related to race on health are far outweighed by social, economic, cultural and political factors. To illustrate this point, Pearce provided the example of a New Zealand study of alcoholism. The study looked at a health-related genetic difference in the form of the ADH2-2 gene which is believed to protect against alcoholism. This gene was found to be relatively common in Maori people but not found in European New Zealanders. However, alcohol-related health problems were found to be more common in Maori than European New Zealanders. Pearce and colleagues suggested that the 'hypothesised protective genetic factors are being outweighed by social, economic, cultural and political factors' (p. 1071).¹⁰⁰

Pearce and colleagues described ethnicity as 'a complex construct that includes biology, history, cultural orientation and practice, language, religion, and lifestyle, all of which can affect health' (p. 1071).¹⁰⁰ They argued that ethnic differences in health have little to do with genetic factors, and are largely related to lifestyle differences (including tobacco, alcohol and drug use), which are determined by historical, cultural and socio-economic factors. For example, European colonisation of the Pacific and America since 1492 resulted in the decimation of many indigenous peoples, largely due to the importation of communicable diseases. However, where indigenous peoples were able to retain their land, so their economic base, food supply and social networks were not severely disrupted, the death rate was relatively low. Pearce and colleagues argued that this demonstrated the importance of environmental factors over genetic factors in ethnic differences in health.

Drug use can vary between ethnic groups.¹⁰¹ For example, the National Drug Strategy 2001 Household Survey identified that people whose main language spoken at home was not English were less likely to drink alcohol, smoke tobacco or use illicit drugs than people who mainly spoke English at home.¹⁰² However, differences in drug use by ethnicity can vary with factors such as the ethnic group, the indicator (for example, country of birth, main language spoken at home), the group's specific history (for example, the reason for immigration and the level of acculturation), the geographic location of the ethnic group, the historical time of the study and the drug in question. For example, while the National Drug Strategy 2001 Household Survey identified lower rates of illicit drug use among people whose main language spoken at home was not English, higher rates of problems relating to illicit-drug use have been identified among Vietnamese communities.^{103 104} As was argued by Pearce and colleagues in relation to health (above), ethnic group differences in drug-use patterns and drug outcomes are likely to be due to social environmental factors rather than genetic factors. After reviewing the literature on social determinants of tobacco, alcohol and illicit drug use, Galea, Nandi and Vlahov concluded that:

while there are racial/ethnic disparities in substance use, most studies suggest that these differences are attributable primarily to differences in socioeconomic status or to availability of drugs rather than to race/ethnicity itself. (p. 41)¹⁰⁵

Similarly, Beyer and Reid concluded from their review of literature relating to ethnicity and illicit drug use that socio-economic status rather than ethnicity was the major contributor to high-risk illicit drug use: ¹⁰⁴

while there is a severe drug problem among sections of the Vietnamese community ... it is directly related to the degree of socioeconomic disadvantage they experience. That is, the greater the disadvantage, the higher the likelihood of an illicit drug problem. (p. 14) ¹⁰⁴

However, socio-economic status is not the only issue for ethnic communities who have migrated to a new country. Experiences relating to being a refugee can be important in relation to drug use. While scant data are available on rates of drug use among refugee populations in Australia, a Victorian report on illicit drug use among ethnic communities concluded that new migrants experience additional vulnerability related to coping with the refugee experience and life trauma, and that this was a key reason for involvement in illicit drug use. ¹⁰⁴ They outlined a number of aspects of the refugee experience that could contribute to drug use, including experiences that resulted in the decision to leave home (for example, war or political persecution), the process of leaving (for example, the loss of family, possessions and status), spending time in refugee camps (for example, violence and trauma) and the process of adjusting to life in a new country (for example, lack of English proficiency, diminishing employment opportunities for unskilled labour, poverty, lack of access to culturally appropriate services, cultural and generational conflict). Research from the United States of America has indicated that the onset of drug dependence among migrants may be delayed for five to ten years after migration (in contrast to depression, which occurred immediately after migration). ¹⁰⁶

A body of research, mainly from the United States of America, has drawn attention to the impact of acculturation on drug use. ¹⁰⁷⁻¹¹¹ Length of time in a new country, particularly when conditions are hostile, has been associated with increased drug use. Delgado reported research from the United States which indicated that differential family acculturation and role reversal or loss of parental control over adolescents by parents who were less acculturated than their children was associated with youth drug abuse. ¹¹² However, this is a complex issue and generalisations across ethnic groups from and in different countries cannot be made.

On the other hand, belonging to a minority ethnic group can also have some benefits in relation to drug use. For example, on the basis of their research on drug use by different ethnic communities in Sydney, Rissel and colleagues concluded that the parenting strategies of some migrant communities (positive parental modelling, active parenting including awareness of or supervision of student leisure time, strict rules about not smoking and less pocket money) might have a beneficial role for drug prevention. ^{113 114}

In summary, racial or ethnic differences in drug use and health are largely a result of historical, cultural and socio-economic factors that are specific to each ethnic group and the host environment and can vary across time. The impact on drug use of belonging to an ethnic group appears to be influenced by structural factors that differentially affect the exposure of the ethnic group to drug risk factors, particularly those relating to socio-economic status. Structures that affect socio-economic disadvantage among ethnic groups include policies relating to the recognition of overseas educational qualifications, and equal opportunity policies, legislation and enforcement.

Maton (summarised above) argued that, as a society, we need to have more respect and appreciation for other cultures in our society.³⁹ Geronimus (Professor of Health Behaviour and Health Education, University of Michigan) argued that social policies not only need to address disadvantage among ethnic groups, but also need to be careful not to exacerbate existing problems among ethnic groups:

to think about social policies, to think about them in terms of how they affect different populations economically of course and in terms of their environment and environmental hazards in their residential environment and work environments, but it also means thinking about the ways in which social policies exacerbate the need to do this high effort coping, to what extent do they fragment already overburdened local social networks, to what extent do they cause psychosocial stress by being implicitly, sometimes explicitly racist, but other times inadvertently racist. To what extent are they affecting the psychosocial conditions of life as well as the material conditions? And bearing in mind always that it is local networks who are taking care of these huge caretaking needs, and so policies need to be particularly as sensitive to not disrupting those networks and if there are ways to support them doing that.¹¹⁵

The Australian Government's policy on multiculturalism emphasises civic duty to support freedom, equality and diversity; respect of people's rights to express their culture; a right to fair participation without discrimination; and acknowledgement of the benefits to all Australians from diversity.^b The *Racial Discrimination Act 1975*^c makes racial discrimination unlawful in Australia. However, some have argued that recent events in Australia such as holding children in detention and the limitations placed on asylum seekers for temporary protection visas suggest that Australian's attitudes and behaviours are not as accepting and fair as they could be.^{116 117} At an individual level, such experience can be stressful and psychologically damaging,^{118 119} which could contribute to individual risks of drug abuse. At a community level, these events can foster racism and inhibit social cohesion, which can contribute to the stress levels of ethnic groups as well as reducing the likelihood that they will actually receive equal employment opportunities — a further risk factor for drug abuse. There appears to be room for improvement in Australian social attitudes, policies and behaviours in relation to ethnic minorities, who can suffer disproportionate discrimination, unemployment, stress and drug-use problems.

The social, economic and cultural characteristics of society

The term 'social structure' can be used to refer to the social, economic and cultural characteristics of society. These characteristics will vary with the level of society under investigation: local, national or global. This section will examine some characteristics of society, at a local-community level and at a global level, that have been considered important for health and well-being, and are likely to influence drug use and drug-use outcomes.

Local community: psychosocial characteristics

Community can be defined by geography (local neighbourhood or city) or by social networks, for example, the 'gay community'. This section is concerned primarily with

^b See <http://www.immi.gov.au/multicultural/australian/index.htm>

^c See <http://scaleplus.law.gov.au/html/pasteact/0/47/top.htm>

geographically defined local communities. Community characteristics include psychosocial (discussed in this section), economic (discussed in Chapter 4) and physical (discussed in Chapter 5) domains. As noted in Chapter 1, the interest of social epidemiologists in community-level risk factors for health has origins in the 1800s. Kawachi and Berkman cited Durkheim's book on sociological method, first published in 1895, to describe the importance of group effects:

The group thinks, feels and acts entirely differently from the way its members would if they were isolated. If therefore we begin by studying these members separately, we will understand nothing about what is taking place in the group. (p. 129)^{120 1982}

Psychosocial characteristics of communities that have received a substantial amount of attention in the past decade are the concepts of social capital, social cohesion and collective efficacy. These are defined and discussed below.

Definitions

The conceptualisation and measurement of social capital and social cohesion are subjects of considerable debate. The terms are sometimes used interchangeably (for example, the World Bank uses the term social capital as a synonym for social cohesion¹²¹), whereas according to some other definitions one is a subset of the other (for example, Kawachi and Berkman describe social capital as a subset of social cohesion¹²²). A maze of definitions and discussions of social capital and social cohesion exists in the research literature^{99 121 123-127}, but we consider the description by Kawachi and Berkman, which incorporates both terms, to be the most useful. According to Kawachi and Berkman, social cohesion is about connectedness between and support for community members:

Social cohesion refers to the extent of connectedness and solidarity among groups in society ... According to Durkheim, a cohesive society is one that is marked by the abundance of "mutual moral support, which instead of throwing the individual on his own resources, leads him to share in the collective energy and supports his own when exhausted". (p. 175)¹²²

Specifically, social cohesion comprises the absence of latent social conflict and the presence of strong social bonds. Forms of social conflict identified by Kawachi and Berkman included 'income/wealth inequality; racial/ethnic tensions; disparities in political participation; or other forms of polarization' (p. 175). Strong social bonds are indicated by three features of society:

1. social capital: trust and norms of reciprocity and mutual aid
2. civil society: a network of voluntary associations that:

hold society together ... keeping individuals from becoming isolated, protecting them from the state, meeting needs that cannot be filled by government, and encouraging more active engagement in the life of the community whilst preserving a degree of choice (p. 179)

3. institutions of conflict management such as a responsive democracy and an independent judiciary.

Thus, according to Kawachi and Berkman, social capital is a component of social cohesion. They emphasised that these concepts are collective, and need to be distinguished from individual-level concepts such as social support and social networks.

Much of the recent focus in the literature has been on social capital. The value of this concept has been criticised.¹²⁸⁻¹³⁰ Whitehead and Diderich have observed:

The academic debate on the relation between income inequality, social capital and health has become something of a minefield, with considerable skill required to tip-toe through the conflicting evidence. (p. 165)¹³¹

In their review of the utility of social capital in research on health determinants, Macinko and Starfield concluded that:

There does not appear to be consensus on the nature of social capital, its appropriate level of analysis, on the appropriate means of measuring it. There seems to be even less clarity on precisely how it might be related to inequalities in health outcomes. (p. 410)¹³⁰

Some critics have argued that the term 'social capital' no longer be used because it is 'obscure in its conceptualisation, varied in its utility and contradictory in its empirical results (p. 161)¹²⁸ and does not improve upon older concepts such as 'community capacity' and 'empowerment'.¹²⁸

Further, as noted by Sampson, social capital is not automatically a positive characteristic of society. Social networks can be used to achieve negative as well as positive goals and used to exclude particular individuals or groups. Sampson gave the example of racial exclusion and the way dense social networks have been used to facilitate segregation.¹³² This potentially negative influence of social capital may be particularly relevant to drug users, who might be segregated or denied services by a community with high levels of social capital, as exemplified by community opposition to the medically supervised injecting centre in Kings Cross, an area known for high levels of public injecting drug use, discarded injecting equipment and overdoses.¹³³

The concept of collective efficacy was proposed in an attempt to address the apparent anomaly inherent in social capital. That is, strong social ties particularly when they are restricted geographically can 'actually produce an environment that discourages collective responses to local problems' (p. 138).¹³⁴ In order to address this anomaly, collective efficacy focuses on mechanisms that facilitate social control without requiring strong ties or associations. Collective efficacy is defined as the linkage of mutual trust and shared expectations for intervening on behalf of the common good. Vinson described collective efficacy as combining the concepts of social cohesion with social control.¹³⁵ In the same way that self-efficacy is task specific, neighbourhood efficacy exists relative to collective tasks. According to Sampson and colleagues, collective efficacy is different from social capital in that social capital refers to the resources or potential inherent in social networks, while collective efficacy refers to task-specific shared expectations and mutual engagement in local social control (p. 138).¹³²

In sum, the concepts of social capital, social cohesion and collective efficacy are related and the differences and relationships between the terms vary throughout the literature. These problems cannot be resolved here. However, given the interest in these concepts

for social and health outcomes, research on their impacts on behaviour and health that is relevant to drug-use behaviours and outcomes is outlined below.

Impacts of community-level psychosocial characteristics

Various reviews exist of the research on the impacts of social capital and related constructs on health and social outcomes, providing mixed results. This is not surprising given the confusion surrounding conceptualisation and measurement of these constructs described above. Some researchers have concluded that the evidence on the role of indicators of social capital (for example, trust, control and organisational membership) on health is equivocal.^{128 136 137} Others, Kawachi in particular, see social capital as an important concept for public health and view the evidence for its explanatory utility as promising. Kawachi and Berkman reported that the benefits of social capital have been examined in relation to:

- families and youth behaviour
- schooling and education
- community life
- work and organisations
- democracy and governance
- economic development
- criminology
- public health.¹²²

Kawachi and Berkman presented examples of the evidence for positive impacts of social capital on crime levels, political participation and public health.¹²² For example, they described research that indicated that social capital at the state level was associated with self-rated health, even after adjusting for individual risk factors (low income, low education, smoking, obesity, lack of access to health care).

Of particular relevance to drug misuse is a review by Sampson, Morenoff and Gannon-Rowley of research on social processes related to problem behaviours among young people and health.¹³⁸ Consistent with the above discussion, Sampson and colleagues found very little consistency in the way social and institutional processes were operationalised or theoretically situated. Constructs overlapped and were not clearly explicated. On the basis of the studies reviewed, Sampson and colleagues identified four classes of neighbourhood mechanisms which, although related, appeared to be independent constructs. These were:

- social ties/interaction (this was also referred to as social capital): level or density of social ties between neighbours, frequency of social interactions between neighbours, patterns of neighbouring
- norms and collective efficacy: the capacity for informal social control and social cohesion, including monitoring of adolescents
- institutional resources: the quality, quantity and diversity of institutions that address the needs of young people, including childcare, health care, educational facilities, recreational infrastructure and employment opportunities
- routine activities: land use patterns and the distribution of daily routine activities (for example, the presence of schools, public parks, shops, industrial units; public transportation; large flows of night-time visitors).

They reviewed the evidence for each of these constructs and concluded that there was strong evidence for links between crime and neighbourhood social processes such as neighbourhood ties, social cohesion and informal social control. Evidence also existed for the role of collective efficacy in neighbourhood crime and community well-being; a relationship between concentrated poverty, disorder, low neighbourhood cohesion and mental distress; a possible mediating role for concentrated poverty and structural characteristics. They found mixed evidence with respect to the relationship between physical disorder and crime. ¹³⁸

There is little research on the role of community-level psychosocial factors on drug and alcohol use and outcomes. The use of tobacco and alcohol tends to be considered an individual-level confounder, controlled for in analyses of the impact of social capital on health. However, given the link between problematic drug use and crime (Chapter 1) and the work of Sampson and others demonstrating links between community-level social processes and crime, it is likely that these processes also impact upon drug misuse. A cross-sectional study of 10,617 randomly sampled residents of 19 counties in Minnesota in the United States by Patterson and colleagues provides some evidence for an association between social cohesion and smoking. ¹³⁹ The relationships between area-level and individual-level social cohesion, feelings of safety (in the home and in the area), poverty and low education on smoking were investigated. The area-level measures were created by calculating the statistical means of the respondents' individual scores within each area. Social cohesion was measured using the community support subscale from a social support index, which included items on the respondent's degree of agreement with the following items:

- (1) People can depend on each other in this community;
- (2) Living in this community gives me a secure feeling;
- (3) People here know they can get help from the community if they are in trouble;
- (4) This is not a very good community to bring children up in;
- (5) There is a feeling in this community that people should not get too friendly with each other;
- (6) If I had an emergency, even people I do not know in this community would be willing to help. (p. 693) ¹³⁹

Analyses investigating individual-level and area-level effects and their interactions identified an association between social cohesion and smoking:

The findings from these analyses add additional support to the literature on the associations of area characteristics with smoking by showing that area level social cohesion and safety measures have important associations with smoking. Each has a significant association with smoking above and beyond their corresponding individual level measures, with area level social cohesion showing the strongest association. These effects hold even after adjusting for area level social deprivation measures (low education levels and high poverty levels) and standard individual level demographic characteristics. Thus, area level factors are not only sources of increased risk, as previous studies have shown, but they also can have protective associations, as area level social cohesion does. Our measure of area level social cohesion is not just the absence of neighbourhood poverty and educational deprivation, as it showed a significant association with smoking after adjustment for those factors. (pp. 695–696) ¹³⁹

Kawachi and Berkman's discussion of the mechanisms by which social capital can impact health provides logical support for considering that the social characteristics of the

community will influence drug-use behaviours.¹²² They described three plausible pathways by which social capital could impact health: '(1) by influencing health-related behaviours; (2) by influencing access to services and amenities; and (3) by affecting psychosocial processes' (p. 184).¹²² Each of these is relevant to drug use. In relation to influencing health-related behaviours, Kawachi and Berkman hypothesised, as we have, that Sampson's research on the impact of social processes on crime is likely to apply to drug-use behaviours. In relation to services, they noted that residents of cohesive communities rally together to ensure services are funded. While this can be useful for mainstream youth services, it can also be directed against services for drug users. With respect to the third possible pathway, social capital/cohesion could increase the levels of available psychosocial support for dealing with problems as well as contributing to self-esteem as a result of mutual respect and sense of belonging. Given the relationships between mental health, stress and drug use (Chapter 1),¹⁴⁰ these emotional benefits could contribute to the prevention of drug misuse. However, the benefits to drug-dependent people will be dependent upon how inclusive and caring that society is in relation to drug users.

Responses/implications

If social capital is an important determinant of health behaviours, including drug use, then the challenge to 'social capitalists' is to describe how government policies can assist the community to contribute to the healthy development of its children.¹⁴¹ Forrest and Kearns have attempted to do so by identifying eight domains of social capital that can be affected by policy.¹⁴² These include: empowerment, participation, associational activity and common purpose, supporting networks and reciprocity, collective norms and values, trust, safety and belonging. Local policies included, for example, establishing local organisations to increase participation. Similarly, Kawachi and Berkman suggested that governments and the private sector could contribute to social capital by subsidising local associations that contribute to social capital such as youth organisations and childcare.

However, Lynch and colleagues have argued that we do not have good guidance on how to build social capital — or even if we should.¹⁴³ They argued that the concept is too poorly conceived or measured for us to be sure about its role, suggesting that its public health utility may have been exaggerated. They warn against overemphasising the influence of the psychosocial environment in understanding health inequalities, as this can lead to an under-emphasis on the role of economic factors and access to resources.

There is a long tradition in community development and community building that is useful in considering how to foster psychosocially healthy communities.¹⁴⁴⁻¹⁵⁰ A number of major community development initiatives have been undertaken in Australia, including a project by Homel and colleagues in Brisbane¹⁵¹ and Baum and colleagues in Adelaide.¹⁵² Principles of community development will not be reviewed here, however, as noted by Vinson, without concerted efforts in communities with existing problems, those problems are unlikely to disappear.¹³⁵

While interventions for disadvantaged communities are important, infrastructure also needs to be universally supportive. For example, education and training, recreation, social supports and so on need to be universally available and of high quality. We need to value strong communities as a preventive mechanism. Further, we need to consider how our systems might be affecting social dynamics. For example, concerns have been expressed that the current trend towards private schools is reducing social cohesion, segregating

children from different religious and socio-economic groups, creating elitism and entrenching class and ethnic divisions.^{153 154} Another example from the research literature indicates that physical aspects of the community, such as transport systems and public spaces, can influence social cohesion. This impact is reviewed in Chapter 5. Few would disagree about the benefits of a cohesive and supportive society. We need to monitor and amend our systems to ensure they contribute to community resilience, rather than fragment it.

Globalisation

The term globalisation has been defined by Arnett:

Globalization has existed for many centuries as a process by which cultures influence one another and become more alike through trade, immigration and the exchange of information and ideas. However, in recent decades, the degree and intensity of the connections among different cultures and different world regions have accelerated dramatically because of advances in telecommunications and a rapid increase in economic and financial interdependence worldwide. (p. 774)¹⁵⁵

The impacts of globalisation on societies around the world have been many. Some impacts have been regarded as positive, some negative. We provide a brief outline below of how globalisation might be affecting factors that can influence drug use: culture, economies and youth development; as well as how globalisation might be more directly affecting drug-use patterns and outcomes.

Culture

It has been argued that globalism is contributing to a mono-culture, with the imposition of Western (particularly American) culture over the rest of the world. For example, Ina and Rosaldo described the pervasiveness of the homogenisation of global culture:

Globalization entails the dissemination of all facets of the West's way of being: from musical forms, architecture and modes of dress to eating habits, languages (specially English), philosophical ideas and cultural values and dispositions — those concerning, for example, freedom, democracy, gender and sexuality, human rights, religion, science and technology. (p. 14)¹⁵⁶

However, as discussed by Ina and Rosaldo, globalisation is not a one-way process of Western cultural imperialism. It has also increased the exposure of Western nations to world cultures and enriched Western cultures.

The impacts of fashion trends as well as Western cultural values on drug use have been discussed in this chapter. Clearly these are global rather than Australian issues. As Ina and Rosaldo noted, the influence of globalisation is a two-way process and we can learn from other cultures. Rissel and colleagues suggested that some harm minimisation strategies could be learned from Vietnamese and Arabic communities.¹¹³ Their recommendation was based on the finding that students from these communities were less likely to drink alcohol and to use cannabis, and spent less unsupervised time with friends than students from an English-speaking background. Further, among the students with a Vietnamese background, spending three or more evenings a week out with friends was associated with higher alcohol use. The challenge, as argued by Maton,

is for our society to respect and learn from different cultures, rather than assuming the dominant (Western) culture is best.³⁹

Economic

Butler, Douglas and McMichael described globalisation as comprising three key elements: long-distance trade, the diffusion of ideas and technology, and capitalism.¹⁵⁷ They argued that: 'This triad, with increasing technological capacity, now threatens the ecological and social fabric of civilisation' (p. 34).¹⁵⁷ In particular, they noted that capitalism is increasingly free of social restraint and has resulted in increases in international inequalities and, in some cases, reductions in public health and education services. They cited the example of Third World countries being obliged to reduce government services to receive continued credit lines, and how this contributed to the tuberculosis and HIV epidemics in sub-Saharan Africa and also to the Rwandan genocide. Other forms of inequality were described:

Real wages for the low-skilled have been static or declining, while at the same time, wages of executives and the highly skilled have increased. Publicly provided services have declined; for the poor and middle classes, promises of 'trickle down' and 'increased capacity' are wearing thin. (p. 37)¹⁵⁷

Within Australia, Butler and colleagues noted how globalisation is contributing to problems in both rural and urban Australia. The loss of tariff protection and the withdrawal of agricultural subsidies have contributed to the decline of rural Australia:

Small family farms either close or become burdened by further debt. Consequently, segments of the rural hinterland become marginalised, rural towns lose services, and critical mass and rural infrastructure decline. ... male youth suicide, depression and the psychological stress of unemployment are impacting on the social fabric of rural Australia. (p. 44)¹⁵⁷

In urban Australia:

Globalisation is producing other mental health effects. The drive for competitiveness with cheap labour overseas has resulted in substantial restructuring of manufacturing industries and in the public service. Industrial awards are giving way to enterprise bargaining. For those in employment, job security is diminishing. Many in employment work long, unpaid hours, and the economic 'imperative' for two incomes in a family adds to the mental stress upon families. (p. 44)¹⁵⁷

There is no reason to believe that the influence of globalisation on risk factors for drug abuse such as stress and unemployment would not result in increased drug abuse as a coping mechanism, particularly when other mental health problems are evident and support services are reduced. Butler and colleagues attributed the increase in drug use among young people to the mixture of urbanisation, homogenisation, environmental degradation and globalisation — particularly the element of marketism — they face. This combination is contributing to young Australians facing chronic uncertainty as the world changes around them, they bear the brunt of unemployment, many feel alienated and powerless.

Butler and colleagues' recommendation to address the problems with globalisation — particularly capitalism — was to harness the creativity and energy of capitalism for the public good. To do this, they suggested a cultural change, whereby social sustainability — rather than economic growth — becomes the centre of social policy:

We observe increasing social preoccupation with individual wealth, greed and self-fulfilment and a diminishing societal capacity and willingness to provide support for those in need ... there is an urgent need to devise countervailing mechanisms to enable human society to reassert human values, and to place human health and genuine well-being at the centre of the social engine. (p. 49) ¹⁵⁷

Youth development

The impact of modern life, which is influenced by globalisation, on youth development has been a subject of considerable research. ^{68 158-163} For example, Arnett posited that globalisation is affecting people's self-identity and the way that they relate to the social environment. ¹⁵⁵ He described four aspects of identity that he considered prominent as issues related to globalisation: bi-cultural identity, self-selected cultures, emerging adulthood and identity confusion. Bi-cultural identity refers to the way that, in addition to their local identity, young people develop global identities that give them a sense of belonging to global culture. Television and the internet are important for the development of such a global identity. In this way, young people can be subject to conflicting cultural influences on behaviour. The notion of self-selected cultures is that people choose to adopt aspects of mainstream culture and subcultures that they find appealing. Arnett describes this as a mechanism by which cultural diversity will be maintained. That is, rather than everybody moving to a single culture, young people self-select into subcultures such as religious groups, the heavy-metal culture or groups that are specifically anti-globalisation.

Emerging adulthood refers to the tendency for young people in developed countries to take longer to move into adulthood than was the case in previous generations. For example, more young people participate in tertiary education and young people marry later and have children later than their grandparents. Arnett noted that this extended period of transition can be a source of identity confusion for some young people. It is this fourth concept that perhaps has most direct relevance to drug use. Arnett proposed that globalisation increases the proportion of young people who experience identity confusion and do not successfully form an identity. This can result in 'an acute sense of alienation and impermanence as they grow up with a lack of cultural certainty, a lack of clear guidelines for how life is to be lived and how to interpret their experience' (p. 778). ¹⁵⁵ Arnett hypothesised that identity confusion among young people could be contributing to drug abuse, as well as to depression and suicide.

Drugs

Research that is specific to the impacts of globalisation on drug use and drug outcomes has described how globalisation has affected drug marketing and drug policy. For example, research has identified concern about the expansion of the global tobacco industry into underdeveloped countries, where there are less controls on tobacco sales, ¹⁶⁴ and about the influence of pharmaceutical business interests on 'Australia's abandonment since the 1980s of a protectionist version of the Keynesian welfare state, in favour of the neo-liberal model of free-trade oriented shareholder capitalism' (p. 2397). ¹⁶⁶ Yi-Mak and Harrison discussed how globalisation has affected the use of tobacco and opium, by increasing demand, by weakening the informal controls and community

strengths of traditional societies, as well as by increasing supply.¹⁶⁷ Wodak described how injecting drug use has spread throughout the world, particularly to Third World countries which are already experiencing problems and so are particularly vulnerable to drug-related problems such as transmissible diseases and crime.¹⁶⁸ He noted:

Illicit drug use is generally more evident in countries making the transition from communism to a market economy and also generally in urban areas where drug markets are easier to operate, provide much-needed income, employment and a temporary chemical vacation from intolerable squalor. (p. 800)¹⁶⁸

Mendes described the recent debate over the proposed introduction of supervised injecting facilities in Victoria and argued that international influences affected the decision not to introduce the service. Mendes concluded: ‘this debate strongly reflected the increasing globalisation of national social policy debates’.¹⁶⁹ We have not presented a comprehensive review here, but have outlined the multiple ways in which globalisation has had direct and indirect effects on drug use and related problems.

Conclusion

This chapter has described a multitude of ways in which culture and social structures affect drug use, either directly or indirectly. While many are familiar with the influence of social norms on drug use and how these can vary with factors such as setting, gender and ethnic group, few are aware of the cultural factors and social structures that are not specific to drug use but which influence individual risk factors (for example, education, employment) and environmental risk factors (for example, stress and the availability of social supports) for drug abuse and other problems. Research indicates that Western cultural values are increasingly influenced by individualism, neo-liberalism, materialism and secularism. While the impacts of these trends are complex and some have been positive, negative impacts have also been identified and these tend to be disproportionately experienced by people from low socio-economic groups. For example:

- Individualism has been associated with an acceptance of the concept of individual responsibility to the extent that people believe it is up to the individual to deal with poverty, to raise children and to manage their drug use. People who fail in these tasks are blamed (or blame themselves). These attitudes have contributed to an erosion of social structures to support families and people in need, including drug-dependent people.
- Neo-liberalism — with its emphasis on individualism and free market capitalism — has contributed to an over-emphasis on economic outcomes and dismantling of social structures such as trade unions, welfare and health services. The assumption that the benefits of economic growth will ‘trickle down’ through society have been found to be unsubstantiated. In fact, neo-liberalism has been associated with higher levels of inequality and lower social cohesion. Drug-dependent people, who are typically the most in need of societal supports, are among the most vulnerable to reductions in worker rights and social services.
- Secularisation has contributed to a loss of shared values, meaning in life and social and parental authority, all of which can contribute to drug use.
- Materialism has been the neo-liberalists’ answer to the search for meaning, belonging and happiness. Yet, research has shown that, after serving basic needs, economic prosperity and material goods have not increased happiness and, to some extent, have

contributed to perpetual dissatisfaction and an inflated work ethic as people strive to pay for material goods.

Changing cultural trends or the negative impacts of cultural trends is not a simple task. However, as argued by Maton, the transformation of the social environment is an essential component of effectively addressing social problems. Maton outlined a set of strategies for cultural transformation including community capacity building, group empowerment, relational community building to improve social cohesion, and ‘culture challenge’ to address the denigration of others and self-absorption that contribute to social problems.

Social experiences are not the same for everyone, and are influenced by social categories such as class, gender and ethnicity. Social category can influence access to resources, exposure to marginalisation and social exclusion, roles and expectations, which in turn can affect health and social outcomes as well as drug use and drug outcomes. 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. Gender differences in drug use are complex but appear to be narrowing as gender-specific social roles have changed. The increased pressure women face juggling family and work responsibilities has yet to be adequately addressed. The impact of ethnicity on drug use is particularly complex, depending on factors such as the reason for immigration and the level of acculturation. Socio-economic factors were found to be particularly influential in contributing to drug use among some ethnic communities. While marginalisation and social exclusion can contribute to unemployment and poverty which can then contribute to drug-use problems, they can also exacerbate drug problems once they are established. Drug-dependent people tend to be caught in a cycle of disadvantage where socio-economic status can contribute to drug abuse; the stigma associated with drug dependence can then contribute to further social exclusion with reduced access to employment and health services. Social policies need to:

- address existing social-group inequalities in drug problems
- ensure that they do not exacerbate existing disadvantages experienced by social groups
- address marginalisation and social exclusion in society as a preventive measure and among drug-dependent people to facilitate achieving and maintaining reductions in drug use and other problems.

In the last decade a great deal of research has investigated community-level psychosocial processes, in particular, the concepts of social capital, social cohesion and collective efficacy. This research has been characterised by a lack of clarity and agreement regarding the conceptualisation and measurement of the constructs. The evidence supporting the impact of these constructs is mixed, although a reasonable amount of evidence links crime with neighbourhood social processes. Despite these conceptual problems, community development and community-building strategies — on a universal and targeted basis — are recommended for creating psychosocially healthy communities that support families to raise healthy children, facilitate the socialisation of young people and assist people with drug-use problems as they occur.

Further, we need to consider how systems (such as the education system, employment sector and public transport) might be affecting our social dynamics — of relevance at both the local community level and the global level. Globalisation is affecting societies

around the world in both positive and negative ways which could influence drug use. For example, Arnett suggested that globalisation results in identity confusion which could be contributing to drug abuse, depression and suicide among young people. Others have expressed concern about the way globalisation has threatened local autonomy, resulting in poorer conditions and increased uncertainty for workers. This, in turn, can impact upon risk factors for drug abuse such as stress, poverty and unemployment. While our understanding of the impact of globalisation on societies and individuals is limited, we must be aware of the changing influences and where possible shape them to minimise negative impacts.

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