

The significance of socio-political context on substance abuse risks and management

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Abstract

This paper will present an argument that it is not possible to 'explore the consequences and remedies of substance use' without considering the socio-political context in which the abuse occurs. The causes and consequences of widespread substance abuse problems are to some extent the product of growing social inequalities within and between communities and nations. Thus, when planning preventive and rehabilitation services and activities, it is essential to consider the national and global socio-political changes which influence substance abuse risks and management. Challenges for achieving successful prevention and treatment approaches centre on the allocation of resources through national policy and social welfare approaches which provide a continuum of strategies from primary prevention to community building.

Introduction

As I sit down to refine this paper with the wisdom of the experience I gained at the Oxford Round Table discussion devoted to this topic in March , 2008, I am even more strongly convinced that as an international community concerned about this issue we must place strong emphasis on creating strong supportive environments around vulnerable people to create a context where it is easier for them to avoid substance abuse and easier for them to remain free of repeated abuse after their rehabilitation.

Background

The use of psycho-active substances is not a new phenomenon, and is not limited to specific cultural groups or geographic location; what differs to some extent, is the historical preferences for 'substances of choice'. Many drugs used today have been used since ancient times; alcohol has been brewed deliberately since 10,000 BC, marijuana was prescribed in China and India as long as 4700 years ago, opium was used for medicinal purposes, even for children, up to 6,000 years ago, and people were chewing coca leaves as early as 3000 BC. Other drugs, such as the chemical compounds manufactured in laboratories, major and minor tranquilisers, amphetamines, ecstasy and LSD have been much more recent innovations (Goldberg 2003). Drugs have the capacity to induce pleasure and reduce pain.

The international significance of substance abuse problems

Alcohol and substance abuse are the cause of increasing problems in the world. In Australia, about one third of the population have used alcohol at a level greater than the recommended level, each week. And about one third have used illicit substances in the past year (AIHW 2001). These two groups of people are more likely than the general population to be diagnosed with, and to seek help for, mental health disorders, ranging from mood disorders to major psychotic events. Alcohol abuse is the main reason for people seeking help for abuse problems

The problems are certainly more evident in developed nations and one reason for this may be that the populations tend to be less influenced by cultural and religious restrictions on alcohol and illicit substance use (AIHW 2001, 33), although there is considerable variation in the patterns of substance use between countries (AIHW 2001, table p.36).

What brings this issue to high international prominence are the increasing social, emotional and economic impacts of related antisocial activities including violence, corruption and dependence. Legal and illegal economic activities are significant considerations for all governments. Legal substances, particularly alcohol, provide a valuable source of income for many governments, through taxation. The trade in illicit substances is huge and showing no signs of diminishing. The illegal use of legal prescription medications is a large and growing problem also. Trade in illicit substances generates enormous profits; profits and monetary exchanges large enough to influence national governments, such as Pakistani production of opium and cocaine trafficking in Colombia.

At a more localised level, is the increasing toll substance abuse takes on individual productive lives and the lost human potential this entails. People's need to access supplies of substances lead them to take illegal and drastic actions. Addiction can have disastrous impacts on individuals and those close to them. (For a more detailed analysis of the economic and social costs of illicit drug abuse in Australia, see Bammer, et al. 2002).

Broadening the agenda for action

The panel of experts in the field assembled at Oxford were deeply concerned about the wellbeing of the individuals they deal with. These people are devoting enormous efforts to understanding the problems and needs of their clients, but at the same time they documented the frustrations of trying to find remedies for abuse, recidivism and its consequences within the context of isolated dysfunctional families in isolated dysfunctional sub-communities, with inadequate resources.

Strategies for affected individuals must be appropriately supported with health promotion, primary prevention and rehabilitation strategies, which are enshrined in policy and adequately resourced (Talbot and Verrinder 2005). If we consider the treatment strategies and therapies designed for affected individuals as a point on a continuum of care, we can then consider a range of other strategies along the continuum designed to prevent and treat psycho-active substance use and abuse which take account of the social context of people's lives ([See figure 1](#)). A full range of approaches is essential in order to minimise the risk of further growth in the number of people affected.

This paper will not explore the nature of the different substances, their effects and options for treatment, and the separate consequences of abuse and addiction, but it seeks to broaden the context of the discussion about the social causes and consequences of substance abuse, with the argument that unless government policy makers and health practitioners provide environments for support of those vulnerable to abuse, then individually focussed and educative prevention and treatment efforts will remain a revolving cycle of treatment, discharge, re-offending, and then waiting for treatment.

Causes, consequences and challenges – the social determinants of health

The first argument to be made in this paper is that it is not possible to ‘explore the consequences and remedies of substance use’ without considering the socio-political context in which the abuse occurs. The second point is that the causes and consequences of widespread substance abuse problems are to some extent the product of growing inequalities in social and community groups within and between communities and nations.

It is to the causes and consequences of socio-political changes across the developed world in the last 40 years we must look to find explanations for the exponential growth of trade in, and use of illicit substances, and for the unequal access to appropriate treatment services.

A great deal has been written in public health literature recently about the social determinants of illness and health. There is clear evidence that people, even within affluent nations, who feel less powerful to make independent decisions, those who are unemployed, lack educational opportunities, live in poverty, have few social supports and suffer with low sense of self-worth, are more vulnerable to the risks of substance abuse and addiction (and Wilkinson 2006). The consequences of inequalities mentioned above, and the impacts that are created on the daily lives of many people, underpin a range of other social, environmental and psychological determinants of ill health, and play a significant role in preventing many people from reaching their full potential as individuals, and as contributing members of society (Marmot and Wilkinson 2006).

International economic globalisation since the early 1970s, driven by a neo-liberal political agenda has been a major factor leading to inequalities within and between nations (Wilkins 2007). Over the same period there has been a parallel growth in the numbers of people affected by substance abuse, and the size of its social impacts (AIHW 2001).

Australia has had more than four decades of unparalleled economic growth. However the growth and economic success carry some very worrying trends below the surface. The richest 10 percent of the Australian population control close to 50% of the national wealth owned by individuals. In contrast, the bottom three deciles have no wealth at all. Indeed, the bottom decile often shows negative wealth—that is their debts exceed their assets. The inequalities apparent in these figures have dramatically worsened in the past decade (ABS 2007; Western et al. 2007).

Substance abuse is like many other illnesses, and it is more likely to affect the more vulnerable members of society than it is those with opportunities and support (Galea and Vlahov 2002). Vulnerable people must deal with issues such as inter-generational unemployment, in families which are forced to the social and geographic margins of towns and cities, where infrastructure is less and family violence and sexual abuse is more frequent (AIHW 2006). School systems which are inadequately resourced to support the social and emotional needs of vulnerable children, create children who don’t succeed in being engaged in the school system at an early age, who never grasp the skills of reading and writing, and don’t develop the social competence and networks this engagement creates.

Inequalities have been created and reinforced through economic rationalist social policy in the education system, in the social welfare system, in infrastructure support, and other areas. A major thrust of neo-liberal policies within nations has been the privatisation of public assets and the adoption of user-pays systems of access to social services which in

some cases were previously universally accessible, especially in health care. The Australian National Drug Strategy 2004-2009 (2004, 6) acknowledges the 'causal chain' of risk between the psycho-socio-cultural determinants of ill-health and the drug system, when it states that:

It has become clear that drug use is but one of a number of social and health problems that can share common determinants, and that these problems tend to cluster in vulnerable individuals and population groups. Equally, it is clear that wide-ranging and broad-based interventions are needed to address these problems in an integrated way across the whole community.

Social and economic determinants increase the vulnerability of some, in areas of personal self esteem, feelings of hope and control (Syme 1998). The determinants make vulnerable members of society more likely to seek out and use mind-altering substances, and also create the conditions in which others will supply and trade the substances. Social circumstances shape behaviour and ultimately influence the health of drug users (Galea and Vlahov 2002). The interrelationships of the social determinants of health can be represented diagrammatically, using the concept of an iceberg, where the mortality and visible impacts of illness are at the top of the iceberg, above the waterline. Morbidity conditions, lifestyle choices and risk conditions are evident below the waterline. At the bottom of the iceberg, are the psycho-socio-environmental determinants of illness (See Figure 2). These factors create the disadvantages and vulnerabilities for members of society. The psycho-socio-environmental life conditions at the bottom of the iceberg also provide the sites where policy decisions and community support impacts will make the most sustained differences to the well-being of those whose lives are affected (Talbot and Verrinder 2005). Individually focussed substance abuse and addiction management strategies are often effective in themselves, but health workers frequently have no choice but to discharge clients back into the abusive vulnerable community from which they came. Most strategies do not change the conditions and circumstances at the bottom of the iceberg.

In a similar fashion, economic rationalist policies and changing global markets have increased inequalities between nations. Many nations have been unable to lift themselves or their people out of grinding poverty, despite the personal efforts of their population, and they feel great despair, and a sense of hopelessness about their future economic prospects. The changing economic conditions have increased hardship for the most vulnerable members of their populations (Labonte and Laverick 2004). In some circumstances the well-being of populations is further undermined by corrupt governance, such as still occurs in a number of African nations. One way out that is frequently put into practice is to enter into illegal activities to access the cash economy; stealing, burglary, prostitution, all of which have direct links to the drug trade.

When we seek to analyse the causes and consequences of these problems we must look broadly to the social and political context of a nation, rather than continuing to focus on the individual abuser. If you wonder at the quality of youth, look to the quality of the society (Kendall and Li 2005). Alcohol and illicit drugs are used by people across the spectrum of socio-economic status (SES), and it is possible to profile the different preferences of people from each stratum of SES. However alcohol and drug-related morbidity and mortality are

disproportionately higher among lower SES groups (Galea and Vlahov 2002). People with addiction and illness problems are most likely to fit the characteristics of the fragmented lives of those 'at the bottom of the social and emotional iceberg'. Members of this group are frequently excluded from taking an active part in society by social and economic disadvantage, or emotional alienation. Perceptions of inequality of limited access to the benefits of society, especially by being unemployed are factors underpinning people's decisions to use substances to prop-up their personal esteem, or to dull their feelings of alienation and hopelessness (Seabrook 1982, cited in Liamputtong and Gardner 2003). At the same time, Australian research indicates that young people generally don't have difficulty in being able to afford alcohol (or perhaps other substances) nor in accessing alcohol, even when they are below the legal age of purchase. These figures reinforce the importance of social and emotional factors in determining behavioural outcomes; the need to use psycho-active substances as a rite of passage, a means of belonging to a group or chosen image or to bolster self-esteem. It is relatively easy to join and 'belong'. In Australia, there are many more venues licensed to sell alcohol opening each year, and they are open virtually all hours. Research indicates that the earlier young people start to drink alcohol, the more likely they are to binge-drink, and the more likely they are to have alcohol related problems, such as brain injury or violence (Sweet 2007).

Challenges for consequences and remedies

In general the philosophy informing The Australian National Drug Strategy 2004-2009 attempts to provide a policy framework for limiting the harm to users and community members. One of the real strengths of this approach has been the links that have been made across government sectors and jurisdictions. However, it can be argued that more should be done, especially at community level, to develop and implement strategies which really provide effective deterrents and prevention mechanisms, and also to minimise the likelihood of re-offending for those emerging from rehabilitation by strengthening the supportive environments around them. This equates to more strategies focussed at each end of the intervention continuum presented earlier in Figure 1.

Drug Policy in Australia

The Australian National Drug Strategy 2004-2009 (2004, 9) seeks to create a partnership approach between government departments in addressing the problem. The Australian National Drug Strategy 2004-2009 (2004) is informed by the principle of harm minimisation. This approach was adopted during the 1980s (Hamilton in Liamputtong and Gardner 2003).

The strategies derived from the policy have a thrust in three directions:

- *supply reduction* strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances;
- *demand reduction* strategies to prevent the uptake of harmful drug use, including abstinence orientated strategies and treatment to reduce drug use; and

- *harm reduction* strategies to reduce drug-related harm to individuals and communities.

(The Australian National Drug Strategy 2004-2009 (2004, 2)

Many aspects of this approach are now internationally recognised for their best practice and innovation in attempts to reduce the supply and use of illicit substances, and to reduce the harm associated with use. Two key factors in the success of this approach over the last two decades, have been the bipartisan approach across the main political parties and the strong collaboration between health and law enforcement in policy and practice (Bammer et al. 2002). However, the previous conservative Liberal Party government of John Howard in Australia was moving away from a harm minimisation approach, and advocating for prohibition in its 'Tough on Drugs' policy before it lost power in late 2007. It is likely the Australian Labor Party, now in office, will continue to support the harm minimisation approach into the future (Macintosh 2007)

Harm minimisation supply reduction approaches seek to intervene in the supply chain. However, despite greater coordination and cooperation between government authorities and the best efforts of policing and drug detection services, with some support from policy-makers, problems associated with alcohol excess and drug abuse are increasing. Alcohol fuelled violence is increasing, especially associated with teenage binge-drinking. Crime associated with drug abuse and addiction is a major problem in some local communities and criminal networks continue to be built and flourish on the profits from drug trade, especially when their activities are facilitated by corrupt officials (Rule and Oakes 2007).

Public health interventions aimed at affecting individual risk behaviour or the immediate risks to drug users' health are not sufficient to address the problems alone. 'A full spectrum of interventions encompassing macro-level considerations (such as policy change to increase economic opportunity and decrease homelessness) and individual-level factors (such as those targeted by many behavioural interventions) should be considered in order to fully address the determinants of disease among drug users' (Galea and Vlahov, 2002, S141). This paper is not a critique of the harm minimisation philosophy or of the hard work and efforts that have been made to implement the strategic approaches set out above. Substance abuse rehabilitation workers could easily feel disheartened, because for every success, there seems to be a whole lot more people in need of help. Each success story comes at the cost of considerable effort and expenses over a prolonged period—the 'quick fix' is not usually an option. Unless people can be discharged into a supportive environment which will foster positive networks of association and provide real alternatives to the networks which have fostered their abusive behaviours, they will have a high probability of re-entering the unhealthy networks of abuse and crime (Marmot and Wilkinson 2006).

The predominance of strategies developed to deal with the consequences of substance abuse still maintain their focus on dealing with the individual person and a specific substance, rather than changing the social context of the issues. Strategies will only be successful within the context of creating a change in social determinants of alcohol and substance abuse.

The common themes which characterise the stories of people affected by substance abuse are that most often they feel a sense of hopelessness and failure; of alienation from their family ties and wider society. The challenges for reduction and management of risk

associated with alcohol and drug abuse is to encompass the social context of the problem as a major factor in planning appropriate management strategies. The social context is made up of those aspects of the social world which influence behaviour. Thus, it is impossible to effectively treat the person as an island, removed from the social influences surrounding him or her. These may include the social group or setting in which the risk or use occurs, including family, schools, workplaces, or meeting places (Keenan in Hamilton et al. eds., 2004). Management strategies must take account of whether other social contexts, such as those provided by health and law enforcement agencies foster appropriate community support also. Media also form a significant, influential, social context, one which can encourage use and abuse, individuality and excess, and one which can also discourage use or provide support.

The culture of excess alcohol consumption has been a part of Australian history since white settlement. It is increasingly the culture of young people to 'go out and get drunk' as the only means of having fun. It is major change to redirect the focus of this culture. In Australia, for example, approaches would include strategies which change or reduce the reliance on social drinking as a normal and necessary part of the cultural identity. Other approaches which have been proposed include tax changes such as incentives for low alcohol alternatives, and taxing all products according to alcohol content. Government policy may also include stricter regulations on sale and marketing, and bans on alcohol sponsorship of sport. Some of these measures have been adopted in Europe, through the European Alcohol Action Plan. However, alcohol companies are major sponsors of the two main political parties in Australia, and there are significant financial returns to the government and to politically persuasive private companies for maintaining the current focus on growth in the industry.

The media can be used by agencies with competing agendas to construct contradictory images of desirable social contexts, such as promoting the acceptability of one form of substance abuse such as the humour and enjoyment of parties where people are consuming excess alcohol but also presenting the inappropriateness of excess alcohol use when driving, such as the very powerful Transport Accident Commission drink driving messages on television in Victoria, Australia (TAC 2008).

Broader harm minimisation approaches need to take account of the social culture of local communities as well as the social context of those who drink to excess or use illicit drugs (Keenan in Hamilton et al. eds., 2004). Thus we need to shift the focus away from the individual alone. Strategies need to protect the abusive user but also protect wider society from that person by reducing the risks in the whole social environment. When we consider this broader perspective of harm minimisation, existing government policy in Australia is in fact commonly harm producing, rather than harm reducing (Keenan in Hamilton et al. eds., 2004).

Governments, such as the state governments in Australia, give mixed messages about the problems of alcohol in society. On the one hand the premier of Victoria describes alcohol as 'the biggest social issue facing Victoria ...'. On the other, 'there are social and cultural interests in maintaining high drinking levels' (Hamilton, cited in Patterson 2007, 11). National competition policy in Australia makes it easier for people to access alcohol, and to drink to excess, 'by easing restrictions on liquor licensing and contributing to a proliferation

of alcohol outlets' (Munro, cited in Sweet 2007: 5). The number of alcohol outlets in Victoria, Australia has doubled in the last ten years (Patterson 2007). In addition, many of the new alcohol varieties that are marketed seem to have been designed specifically for the young, female drinkers, such as fruit cordial mixers, or 'alcopops' (Ferguson 2007). This is a major social policy agenda item. Despite the predominance of social and medical costs arising from excess consumption of alcohol, compared to illicit drug use, Australian funding for health interventions has been heavily skewed towards addressing drug abuse (Mackay 2007).

If we consider the quality of the social context of people's lives we know that people who are strongly linked into a supportive community network of associations with others are healthier and more resilient (Syme 1998). Those who feel unsupported and alienated from their community networks are more likely to suffer physical and mental illnesses, and to rely on the psychological crutch of substance use and abuse to compensate for their sense of isolation and sense of hopelessness (Marmot and Wilkinson 2006).

For those with problems of addiction, peer-based education and support programs, and their active involvement in the development of education and treatments programs is necessary. Successful examples have included a community arts development project, such as those financially supported by Rotary International and other service clubs. The *Youth Arts Network* in Bendigo, Australia has a youth mentoring project and the *Chutzpah Factory* is calling for participants in a practical course for business and entrepreneurship skills development. The City of Greater Bendigo offers a Neighbourhood Party Trailer where tables, chairs and BBQ equipment are made available to groups wishing to hold a small neighbourhood gathering. <http://www.bendigo.vic.gov.au/index.asp?h=-1>

Similarly, involving users in the formulation of policy is an essential step; policy that assists their assimilation into strong community networks of support – which are likely to be sustained in the challenging times when a person is seeking to distance themselves from the social context that previously supported their use. These processes require the development of strong linking social capital through social policy and infrastructure support (Szreter 2002).

Local government, through its strong links to local community organisations and planning structures has a significant role to play in engaging community members, across the spectrum, in changing the culture of alcohol and substance abuse. An example of this is the *Good Sports* program, which seeks to tackle a range of anti-social outcomes of the drinking culture that is characteristic of many sporting clubs. The *Good Sports* program has been particularly successful in country towns where the sporting clubs have been a social centre, and strong social capital still remains. The program draws on the social capital and incorporates aspects of social and cultural change into the existing networks. In many cases these sports clubs have become thriving community centres where people of all ages feel welcome and comfortable (www.goodsports.com.au). The other advantage of this approach is its whole-of-community focus, rather than a focus on an individual (Hamilton and Rumbold in Hamilton et al. eds., 2004).

Other whole-of-community successes include neighbourhood renewal projects, such as the Shared Action project centred on the suburb of Long Gully in Bendigo or the inspiring

story described by Andrew Mawson of the project in Bromley by Bow in inner city London (www.bbbc.org.uk/).

The principles set out in the harm minimisation approach allow for considerable flexibility and pragmatism on the part of policy makers and health professionals (Hamilton and Rumbold in Hamilton et al. eds., 2004). The principle of harm minimisation can be applied to all psychoactive drugs, whether they are licit or illicit—they all have the potential to cause harm to an individual and thus to wider society. ‘This recognises that the legal drugs, alcohol and tobacco, impose a significantly greater burden on the community in terms of social and economic costs’ (Hamilton and Rumbold in Hamilton et al. eds., 2004, 138). Implementation of the principles needs to be broadened to include policies and agencies dealing with social, environmental issues and risks as well. These sectors need to work more successfully across borders or policy areas to reduce the silos of practice and increase collaboration and efficiencies, and to provide networks of support.

Conclusion

Losing sight of the main goal of prevention, and having the focus on secondary (acute care) management for those individuals affected, will result in fragmentation of services and undermining the social determinants of health that comprehensive approaches seek to strengthen. Major challenge with intersectoral approaches, such as those advocated here, are the difficulty in arguing for the redirection of additional health policy resources to prevention and community approaches, and in demonstrating through evaluation, that particular strategies have been responsible for a specific improvements, or reductions in risk.

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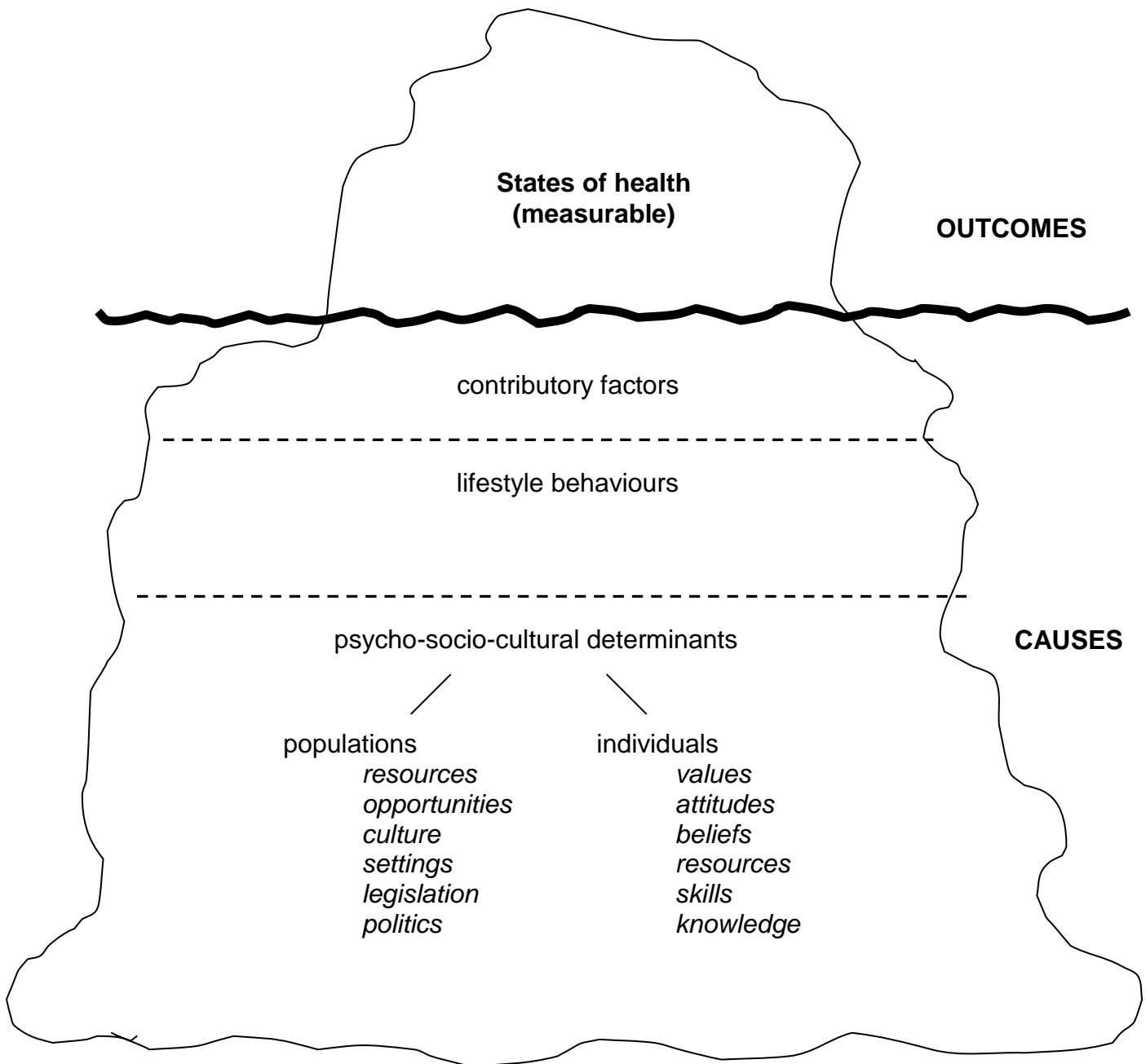
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| Health Promotion | Primary Prevention | Secondary Prevention (Acute Individual Care) | Tertiary Prevention (Rehabilitation) |
|---|---|---|---|
| Community Building Incarceration | Health Education classes in schools | Harm minimisation policy | |
| Social Capital Alcoholics' Anonymous | Social Marketing – drink driving advertisements | Drug therapies | |
| Community support programs Police powers | Drink driving legislation | Hospitalisation | |
| Alcohol and drug policy Alcohol and drug policy | Harm minimisation policy | Psycho-therapy | |
| Educational support Support groups | Family therapy | Family therapy | |
| Family accommodation support Reducing homelessness | Truancy management | Social capital | |
| Changing the social culture building | | | Community |
| Taxation incentives Restrictions on alcohol sales | | | |

Figure 1: A continuum of interventions for substance abuse

Figure 2: The Health Iceberg



Reference : Travis, J., and Ryan R. 2004, cited in Talbot, L. and Verrinder, G. 2005, *Promoting health. The primary health care approach, 3rd ed.* Sydney: Elsevier, p.21.